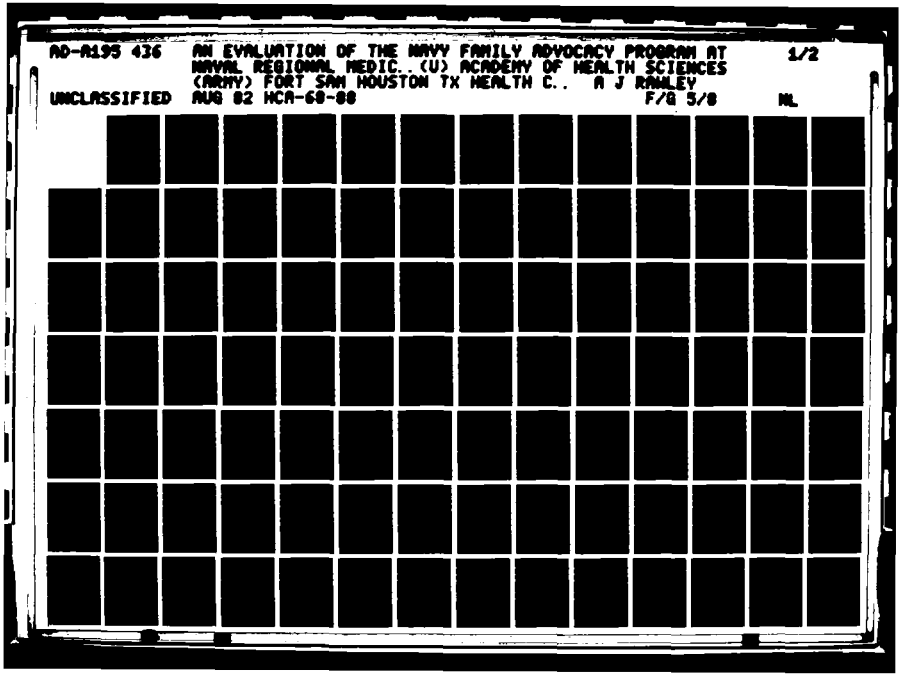
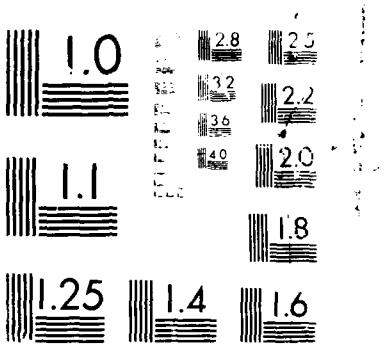

AD-A195 436 AN EVALUATION OF THE NAVY FAMILY ADVOCACY PROGRAM AT NAVAL REGIONAL MEDIC..(U) ACADEMY OF HEALTH SCIENCES (ARMY) FORT SAM HOUSTON TX HEALTH C.. A J RAWLEY
1/2
UNCLASSIFIED AUG 82 HCA-60-88 F/G 5/8 NL


1.0
1.1
1.25
1.4
1.6
1.8
2.0
2.2
2.5
2.8
3.2
3.6
4.0

(2)

AN EVALUATION OF THE NAVY FAMILY ADVOCACY PROGRAM AT NAVAL REGIONAL MEDICAL CENTER CAMP PENDLETON, CALIFORNIA

A Graduate Research Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Health Administration

by

Commander Anne J. Rawley, NC, USN

August 1982

SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

Form Approved OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION Unclassified	1b. RESTRICTIVE MARKINGS
2a. SECURITY CLASSIFICATION AUTHORITY	3. DISTRIBUTION / AVAILABILITY OF REPORT Approved for public release; Distribution unlimited
2b. DECLASSIFICATION / DOWNGRADING SCHEDULE	
4. PERFORMING ORGANIZATION REPORT NUMBER(S) 68-88	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION US Army-Baylor University Graduate Program in Health Care Admin/HSHA-IHC 6b. OFFICE SYMBOL (If applicable)	7a. NAME OF MONITORING ORGANIZATION
6c. ADDRESS (City, State, and ZIP Code) FT Sam Houston, TX 78234-6100	7b. ADDRESS (City, State, and ZIP Code)
8a. NAME OF FUNDING / SPONSORING ORGANIZATION 8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO. / PROJECT NO. / TASK NO. / WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
AN EVALUATION OF THE NAVY FAMILY ADVOCACY PROGRAM AT NAVAL REGIONAL MEDICAL CENTER CAMP PENDLETON, CALIFORNIA

12. PERSONAL AUTHOR(S)
COMMANDER ANNE J. RAWLEY

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Study	FROM JUL 81 TO AUG 82	AUG 82	175

16. SUPPLEMENTARY NOTATION

17 COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	
			HEALTH CARE; CHILD/SPOUSE ABUSE; FAMILY ADVOCACY; public health; medical services

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

This study examines the development, implementation, and results of a Family Advocacy Program to determine if the program meets standards imposed by the Navy Bureau of Medicine and Surgery (BUMED). Programs for identification, intervention, treatment, and prevention of child abuse, spouse abuse, and sexual assault were studied. The author concludes that the Family Advocacy Program studied fails to meet the standards imposed by BUMED, and argues that this indicates the standards are unrealistic given the lack of additional resources allocated to the facility for the program. The author recommends that control and coordination of the Family Advocacy Program at the local level not be delegated to the medical command, but rather to the larger military community via the chain of command. Keywords: theses.

20. DISTRIBUTION / AVAILABILITY OF ABSTRACT	21. ABSTRACT SECURITY CLASSIFICATION
☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT. ☐ DTIC USERS	
22a. NAME OF RESPONSIBLE INDIVIDUAL Lawrence M. Leahy, MAJ(P), MS	22b. TELEPHONE (Include Area Code) (512) 221-6345/2324
22c. OFFICE SYMBOL HSHA-IHC	

DD Form 1473, JUN 86 Previous editions are obsolete. SECURITY CLASSIFICATION OF THIS PAGE

ACKNOWLEDGEMENTS

Successful completion of a research project requires assistance and input from sources too numerous to mention. However, certain individuals and departments at Naval Regional Medical Center, Camp Pendleton deserve separate recognition because of the extra effort they expended in assisting me with this project. The medical librarian, Deborah Batey, was invaluable in providing the literature searches and resources required for the review of the literature and for the statistical data. The data collection could not have been accomplished without the reproduction of the numerous survey tools required. HM1 Larry Woods and his staff in the Duplication and Reproduction Section of the Operating Management Service provided rapid and responsive service in duplicating the many copies required.

Of course, I must acknowledge the continued interest, support, and constructive criticism provided by my preceptor, Commander Everett L. Wilson, MSC, USN, Director of Administrative Services. Without his encouragement, I know that I would have encountered great difficulty in developing and completing this project.

Finally, I would be remiss if I failed to mention the continued inspiration of my fellow resident, Lieutenant John Wocher, MSC, USN, who provided constant reassurance and rallied my sometimes flagging spirits during the arduous task of conducting and eventually concluding this research.

Anne J. Rawley

June 1982

TABLE OF CONTENTS

LIST OF ILLUSTRATIONS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Development of the Problem

Background

In the 1970's the issue of domestic violence in society, that is violence within the family unit, began to achieve recognition not only by health, legal, and social services professionals, but also by the lay public. The proliferation of research studies and increased public sector attention fostered the development of organized state and community programs to deal with destructive behavior within the family. Prior to this time, efforts had been isolated and sporadic because of a general reluctance to interfere or intervene in family matters and a lack of understanding of the problems. However, the growing awareness that family violence, resulting in child maltreatment or spouse abuse, was not just a medical or social problem, but the result of a combination of complex factors, generated efforts to develop comprehensive and organized programs to deal with family problems.[1]

Many societal changes have occurred in this century which have changed family life. The current small, flexible,

nuclear family has adapted to rapid societal changes, such as industrialization, but not without significant difficulties. The American family today is unsettled, changing, shifting, moving from a known past to an uncertain future. Pressures are internal as well as external. The roles of family members are no longer well-defined and rigid. Differing expectations exist between members of families and from one family to another. Many of these expectations are intangible with numerous choices available of which ones to accept and which ones to reject. Because of the lack of role definition within the family unit and the ever-changing demands, choices, and expectations, there is no longer an easy way to teach adult role behavior. Increasing freedom and instability both inside and outside the family unit have forced a change in the image of family life. The family is now seen as a nurturing center for human development and the primary agent for basic mental, as well as physical, health.[2]

Recognition of the primary importance of the family to the health and productivity of the society, as well as to that of the individual, has fostered the growth of community efforts to support and assist families who are experiencing difficulties of any kind. These efforts are seen at the federal, state, and local level, but no matter which level is examined, the focus is shifting from one of helping an individual to one of assisting the family as a whole.

While the concept of treating families as a whole has

gained greater acceptance, initial efforts have been directed at specific categories of individuals who found themselves victims of domestic violence (Appendix A provides definitions of this and other terms used throughout this paper). By the late 1960's most states had enacted child abuse reporting laws aimed at identifying and protecting the child victim of family generated maltreatment.[3] Legal remedies for victims of spouse abuse appeared much later, but by the late 1970's almost every state had enacted legislation which strengthened both civil protection and criminal penalties.[4] Sexual assault, while legally recognized as a crime, has received varying judicial treatment depending upon whether the act occurred within or outside the family unit and whether or not the victim was a child or an adult. No matter what the circumstances of the sexual attack, it has been increasingly recognized, both legally and socially, that such an event results in detrimental effects upon the individual and his or her family.

Legal and judicial recognition of the deleterious effects of family violence has helped to increase the availability of resources dedicated to assisting individuals and families in coping with and overcoming the devastating results. This is not to say that all programs have become publicly supported, but rather that there is greater cooperative effort between institutions, both public and private. In the area of child maltreatment, this has become particularly

obvious as evidenced by the coordinated programs of the juvenile courts, police departments, hospitals, schools, and welfare agencies in casefinding, protection, and treatment for victims and their families. In fact, the endeavors to provide for child welfare and protection have undoubtedly shown the greatest multidisciplinary collaboration.

The military community, whether or not it is viewed as a subculture of the larger civilian society, has followed in the same direction as its civilian counterparts by initially developing multidisciplinary programs to respond to perceived problems in child abuse and neglect among military beneficiaries. The armed services were slower than the civilian community in recognizing and reacting to the problem of child maltreatment for a number of reasons. One reason was the geographical scattering of military committees throughout not only the United States, but also the world which resulted in a fragmented perspective of the problem of child abuse.[5] Another reason was the fact that there was not clear evidence that family problems, such as child maltreatment, threatened military effectiveness in the same way that racial discontent or drug abuse impaired combat readiness.[6] Probably the single most important explanation was the fact that while the military organizations were not hostile to family life, they did not in any way encourage it.[7]

Changes in the military organization over the past decade have resulted in a reversal of some of the long held

opinions of military and political leaders regarding military families. The end of the draft and the introduction of the all-volunteer force resulted in many new enlistees entering the armed services already "equipped" with a spouse and sometimes one or two children.[8] In the Navy alone, twenty percent of the first term enlistment force and eight percent of the career force are married.[9] Single parent families, working spouses, and marriages where both spouses are active duty military are all phenomena that have helped change the traditional views of the military family. Recognition that retention and on-the-job performance are related to family satisfaction and functioning has resulted in increased attention paid by military and political leaders to family disharmony and conflict at the family/organization interface.[10] Efforts to improve economic benefits and support services were one result of this recognition of change.

Another result was the increased attention given to the problem of violence within the military family when it became evident that this violence might be symptomatic of inability to cope with the stresses of military life. Much of the early attempts at dealing with this problem were centered in armed services medical treatment facilities and focused on the identification of victims of child maltreatment. These early endeavors included the formation of child protection teams such as the Infant and Child Protection Council established in 1967 at the William Beaumont Army

Medical Center in El Paso, Texas.[11] This multidisciplinary and interdisciplinary approach served as a model for other military medical facilities.[12]

However, it was not until the middle of the 1970's that service-wide regulations were promulgated to deal with child advocacy. As already noted, reporting laws regarding child maltreatment were, by then, passed in most states. In addition, many states were setting up central registries for the recording cases and were providing legal immunity for those who reported child abuse in good faith.[13] The passage of P.L. 93-247, the Child Abuse Prevention Act, by the Congress in January 1974, provided additional impetus to the joint efforts of the Surgeons General of the three services to develop coordinated regulations.[14] The Air Force regulation, AFR 160-38, became effective on April 25, 1975 and established the first service-wide child abuse and neglect program. Army Regulation 699-48, establishing the Army Child Advocacy Program, became effective February 1, 1976. On February 4, 1976, the Navy's Bureau of Medicine and Surgery (BUMED) issued Instruction 6320.53 which established the Child Advocacy Program to be administered by Naval medical facilities.

While the intent and scope of the three services' regulations are similiar, variations in organization and responsibility are inherent in each. The Air Force program is managed by the Director of Professional Services in the

Office of the Surgeon General.[15] Every major Air Force command has a child advocacy program coordinator with the installation commander responsible for overall program operation. Each installation has a Child Advocacy Committee, chaired by the director of medical services or the chief of hospital services. A senior clinical social worker from the medical center or regional hospital acts as a consultant for the local program and committee. The committee is multidisciplinary with representatives from the legal, police, religious, and personnel units. The child advocacy program coordinator serves as the liaison between the military installation, civilian welfare agencies, and the courts.

The overall responsibility for the Army program for child advocacy is delegated to the Adjutant General, who must provide resources and technical assistance for child welfare services. Child Advocacy is now one of the six major components of the Army Community Services Program.[16] The Army's Surgeon General is responsible for program support by providing medical care, establishing a data collection system, and supervising aspects of identification, prevention, and treatment of child abuse and neglect. The Chief of Chaplains, Chief of Information, and Judge Advocate each have responsibilities for program support within their areas of expertise. At the local level, installation commanders must establish a child advocacy program with an officer to supervise the program. In addition, each installation must have a

child advocacy/human resources council for assessing the need for and developing preventive and educational programs to support the child advocacy effort. The installation's hospital commander must provide a multidisciplinary child protection and case management team to assist in evaluation, diagnosis, and treatment of maltreated children. A hospital social worker or nurse must be designated to receive and act upon cases referred to the medical facility.

The Navy's efforts in child advocacy evolved into a significant departure from those of the Army and Air Force. A more lengthy discussion of the Navy program follows in order to achieve a full appreciation for its effect at the local level.

Navy Family Advocacy Program[17]

In contrast to other services' programs, the Navy program for child advocacy is the responsibility of the Bureau of Medicine and Surgery. In 1979 the original Child Advocacy Program was expanded to include spouse abuse and sexual assault programs. It was incorporated into a total Family Advocacy Program, outlined in BUMED Instruction 6320.57, and applicable to all BUMED medical and dental treatment activities. Family advocacy, as defined in the Instruction, includes identification, evaluation, intervention, treatment, and prevention of abuse, neglect, sexual assault, and rape.

The Chief of the Bureau of Medicine and Surgery is

responsible for establishing broad policies regarding the Family Advocacy Program throughout the Navy Medical Department. A Central Family Advocacy Committee was established including representatives of the Surgeon General, Judge Advocate General, Naval Military Personnel Command, Commandant of the Marine Corps, Chief of Chaplains, and other appropriate commands. This committee is responsible for:

--Submitting recommendations regarding program management and expansion to the Chief of the Bureau of Medicine and Surgery and the Head of the Family Advocacy Program.

--Forming three major committees on child abuse and neglect, spouse abuse and neglect, sexual assault and rape. Each working committee will review Navy and Marine Corps cases submitted to the Central Registry on a monthly basis; submit recommendations concerning disposition of cases to the Chief of the Bureau of Medicine and Surgery and the Head of the Child Advocacy Program; and submit recommendations regarding program management and expansion to the Central Family Advocacy Committee.

The instruction specifies that the Head of the Family Advocacy Program is responsible for:

--Ensuring that all Bureau of Medicine and Surgery activities establish a Family Advocacy Program in compliance with this instruction.

--Assisting local commands in implementing this instruction.

--Overseeing the functioning of Family Advocacy Programs at all Bureau of Medicine and Surgery activities.

--Maintaining statistical reports on all suspected cases of abuse and neglect (without identifying information).

--Maintaining a central registry of all established cases of abuse and neglect.

--Submitting program recommendations to the Chief of Bureau of Medicine and Surgery.

Commanding officers of all Naval medical and dental treatment facilities are responsible for implementing local Family Advocacy Programs. They are expected to use incidence data as a management tool for evaluating and improving their programs and to maintain liaison with appropriate line committees in order to effectively implement and manage local programs.

Naval Commanding Officers of regional medical centers and hospitals are required to establish local policies and directives for implementation of a Family Advocacy Program at their commands. A social worker or, in the absence of a social worker, a senior member of the command must be designated as the Family Advocacy Representative. This individual's duties consist of implementing and managing the local Family Advocacy Program. A roster of Duty Family Advocacy Representatives is required. These individuals are to serve as adjuncts to Family Advocacy Representatives or to assume their duties in their absence.

A standing Family Advocacy Committee must be established that includes: lawyers, pediatricians, gynecologists, psychiatrists or clinical psychologists, chaplains, dental officers, social workers, pediatric, health care administrators, and others deemed appropriate by the commanding

officer. The Family Advocacy Committee submits recommendations on program management and expansion to the commanding officer. This Committee also ensures that all subordinate medical facilities establish local directives and reporting procedures in support of the Family Advocacy Program. The committee is divided into three working committees on child abuse and neglect, spouse abuse and neglect, and sexual assault and rape. These working committees are responsible for:

--Reviewing suspected cases and evaluating the quality of services provided.

--Ensuring that each reported incident of child abuse and neglect is reviewed in a timely manner and evaluated as either unfounded, suspected, or established maltreatment.

--Planning for definitive management of individual and community problem situations relating to abuse, neglect, and sexual assault.

--Submitting recommendations concerning disposition of cases to the commanding officer.

--Submitting reports of suspected and established maltreatment to the Chief of the Bureau of Medicine and Surgery and the Head of the Family Advocacy Program.

--Making recommendations regarding program management to the Family Advocacy Committee.

Where a victim of child abuse or spouse abuse is considered to be in imminent danger, the regulations indicate that a medical officer must initiate immediate action. This

may include removal of the victim, providing required medical care or hospitalization, securing protective custody in child maltreatment cases and/or providing shelter care. The instruction emphasizes that military and civilian agencies must work together to ensure rapid intervention in emergency cases. Local policies for reporting suspected or known abuse, neglect, sexual assault and rape are estabished in accordance with applicable state and local laws. All military individuals are encouraged to report all such incidents directly to the Family Advocacy Representative who will in turn report to the appropriate local or state agency.

The instruction states that in cases of suspected and established maltreatment the diagnosis shall consist of a brief statement as to whether the abuse or neglect was intentional or unintentional. In addition, the type of abuse or neglect should be indicated. Interagency and interdisciplinary cooperation and sharing of information regarding treatment needs is considered crucial. Recommendations concerning treatment must be made available to the perpetrator's command and all military and civilian agencies with disciplinary authority over the perpetrator.

The Family Advocacy Program includes both primary and secondary prevention efforts. The former are designed for the general military population to help them maintain adequate levels of functioning. Programs such as child care, health and dental care, religious programs, and recreational

facilities are required to be evaluated for their effectiveness in primary prevention. Secondary prevention is directed toward individuals and families "at risk" of child abuse or neglect who have not yet evidenced abusive and neglectful behavior. Services must be designed to assist these families in overcoming current areas of dysfunction.

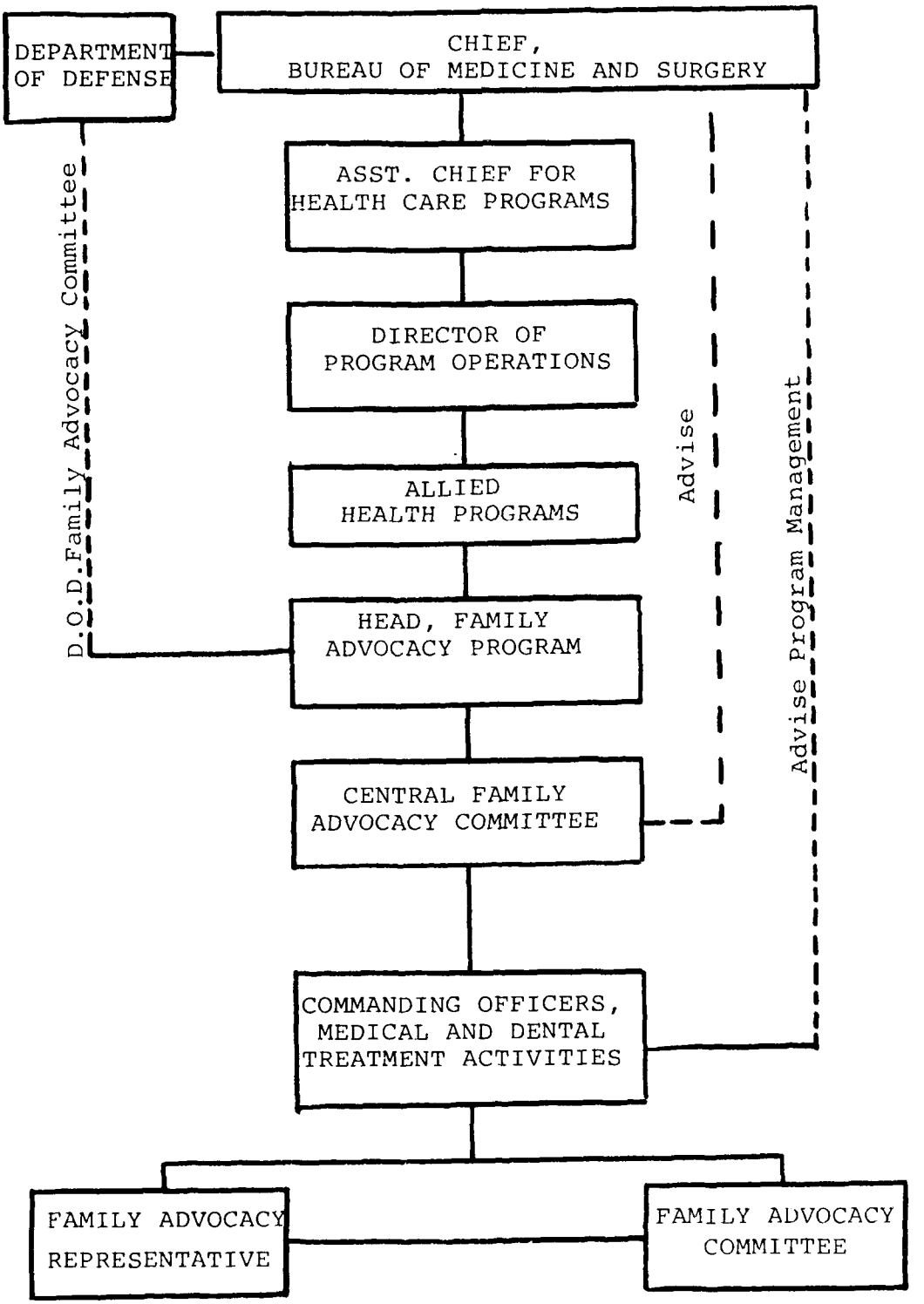
It is evident that each command has a unique relationship with the civilian community in which it is located. In the absence of specific national standards, each command is required to implement and manage its Family Advocacy Program within applicable local, state, and federal laws and the Bureau of Medicine and Surgery guidelines and requirements. Figure 1 illustrates the organizational structure of the Navy Family Advocacy Program.

Conditions Prompting the Research

From the foregoing discussion, it becomes obvious that a significant amount of resources is required to comply with BUMED requirements and guidelines for the Family Advocacy Program. At Naval Regional Medical Center, Camp Pendleton, California, the dilemma of providing the resources necessary was becoming more apparent as the local program expanded.

The medical center is located on a large Marine Corps reservation on the southern coast of California. The beneficiary population averages approximately 190,000 including about 40,000 active duty personnel, 17,000 retired service

Fig. 1 Organization of the Navy Family Advocacy Program[18]



members and about 130,000 dependants.[19] The core hospital has a 600-bed capacity but is currently funded and staffed for 185 beds. With regionalization the medical center acquired responsibility for managing the thirteen area branch clinics located on Camp Pendleton and the adjacent Naval Weapons Station; the Branch Hospital at Marine Corps Air-Ground Combat Training Center, Twentynine Palms, California; and the Branch Clinic at Marine Corps Logistic Support Base, Barstow, California; and the Branch Clinic at the Marine Corps Mountain Warfare Training Center, Bridgeport, California. The mission and tasks of this large regional medical activity are numerous, but the primary responsibility remains to provide clinical and hospitalization services for active duty Navy and Marine Corps personnel. The assets of NRMC Camp Pendleton must be utilized to fulfill primary and secondary missions and functions (a full description of mission and tasks of the NRMC is provided in Appendix B).

The Family Advocacy Program is actually only one among the many medical programs operated by the medical center. The staff of the Social Work Service provides for social welfare assistance to inpatients and outpatients. One of the major activities of this branch of the Psychiatry Service is the daily management of the Family Advocacy Program (FAP). The staff of the Social Work Service consists of three full-time social workers, two of which are civilian employees and one of which is a commissioned officer, and two

civilian clerk-typists. One clerk-typist has received on-the-job training to provide casework assistance. In addition, other medical center staff members, including physicians, dentists, nurses, and administrative personnel, play active roles as representatives on the Family Advocacy Committee (FAC) and its working subcommittees. Local military units and civilian agencies also send representatives to participate in the committee activities. These are the liaison people with whom the Family Advocacy Representative (FAR) must work in case management.

The commitment of all these resources to the Family Advocacy Program has raised a number of questions at the local command level. For example, one question is: Does the program get results? In other words, is the program able to intervene and treat victims, provide for identification of and assistance to high risk families, and develop a general population-wide prevention program? The perception seems to be that Family Advocacy is a program without limits, yet resources at any medical facility are limited as are the resources in the surrounding military civilian community.

The finite nature of its resources and the many different programs which the medical center must support pose a significant management dilemma. The Family Advocacy Program, with its broad requirements and guidelines, could easily consume a large share of the assts and manpower available. Compliance with such an all-encompassing program without

evidence of specific outcomes or results can certainly lead managers to become discouraged and, ultimately, to cut back on the resources allocated to the program. Unfortunately, BUMED has not yet provided any specific criteria or measures of program effectiveness. Thus, the information for the local command to use in making resource decisions regarding Family Advocacy is not easily obtainable or obvious.

Statement of the Research Question

The dilemmas and questions continually arising about the Family Advocacy Program indicated the urgent need for a comprehensive study in terms of requirements, implementation, and results. The primary question to be addressed by the research project is summarized as follows:

> Is the Family Advocacy Program, as required by BUMED Instruction 6320.57, realistic and manageable at the local command level, and is it effective in accomplishing its objectives of: Intervention, Treatment, and Prevention?

Limitations on the Research Study

The most obvious limitation on any study involving the Navy Family Advocacy Program is the lack of tested and proven measures of program effectiveness. Because of this limitation, development of the research project required utilization of methods suggested in other studies. Although the use of incidence data as a local management tool for program

evaluation was suggested by the BUMED guidelines, there were no standards provided against which to measure such information.

Two other major limitations affected the research effort. First, the lack of computer support at the medical center meant that data had to be manually collected and analyzed. Second, because no manpower could be provided, all data had to be collected and analyzed by the researcher alone.

Other Factors Affecting the Research

One significant factor which had to be constantly considered in terms of the findings and the conduct of the research was the limited amount of resources available to the medical center in fulfillling its mission and tasks. Not only are these resources limited, but also they are constantly changing, often at the direction of authorities far removed from the local situation. What this means is that programs such as Family Advocacy are dependent upon the interest displayed not only by local commanders and staff, but also by higher authority.

Review of the Literature

Overview

While much literature is available addressing program design and evaluation for specific social problems, none

could be found which presented or discussed family advocacy as a unified concept with which to approach child maltreatment, sexual assault, and spouse abuse. A program based on this idea seems to have originated within the Navy Medical Department. Yet, the principle of assisting families as units or of helping individuals as members of a larger organizational community is not new, as evidenced by the fact that all the armed services have developed family service centers at the installation level. Also, family therapy has long been one modality in the many forms of psychotherapy.

McCullah suggests that research into the interrelationships among the types of family dysfunction, such as spouse abuse and child maltreatment, is still in an "embryonic stage".[20] He goes on to state that, in the military community, the problem still remains to convince Congress that family dysfunction and the resulting personnel problems detract from the time and energy available for primary mission accomplishment and, thus, compromise the nation's defense capabilities. More resources devoted to training professionals, such as physicians, to identify family dysfunction would, according to McCullah, go a long way to improving the situation. However, he states that the current categorization and program organization of alcoholism, drug abuse, spouse abuse, and child abuse as distinct clinical entities overlooks the empirical evidence that these problems are strongly interrelated, both in the civilian and military

communities. Finally, McCullah makes a strong case for the role of the clinical psychologist on the Child/Family Advocacy Team both as a provider of treatment to families and as an educator for other team members.

In a related analysis, Nichols also decries the lack of data on family dysfunction and its effect upon the military organization.[21] He also believes that military leaders and family service workers are often ignorant of each others' responsibilities and programs. Poor communication then results in a lack of the needed coordination between military families and military organization. While Nichols is aware that reconciling the conflicting priorities of military leaders and family specialists is not easy, he states that developing specific indicators of measures of both positive and negative family functioning would go a long way to bridging the communications gap. Currently, stress is often viewed as producing only negative effects on families. Yet, there is no hard data to support that hypothesis. Another criticism, voiced by Nichols, is the lack of organizational structures that provide clear authority and workable procedures for dealing with family concerns and for integrating family issues into the broader concerns of military operations and management.

The lack of comprehensive family research and programs was not found to be restricted to the military community. Review of program design and evaluation liturature

regarding civilian efforts indicated the same deficiency. In order to present the remainder of the findings, it was deemed appropriate to present each category separately.

Child Abuse and Neglect

Child maltreatment has received the greatest amount of attention in terms of ressearch undoubtedly because it has been legitimized as a social, medical, and legal problem. A great deal of this investigation has been devoted to identifying the causes of the problem. However, this review, by project definition, was confined to the literature which addressed program development and evaluation.

The concepts of a multidisciplinary team approach, utilizing members from the professional, medical, legal, and social work groups, and an interdisciplinary cooperative effort between the health care system and the community-based welfare and judicial agencies is well-documented in the literature. In fact, no research was discovered which supported a unidisciplinary program for child abuse and neglect.

At Children's Hospital in Ottawa, Canada, a child abuse team was formed in 1974 for the purpose of detection and short-term management of child abuse cases.[22] This team included pediatricians, psychiatrists, emergency room nurses, and case workers from the Children's Aid Society. The reason the team was hospital based, according to author Fitzpatrick, was that so many referrals came through the

emergency room of the hospital. The reason for a team approach was because of the need to gather as much information as possible prior to decision-making. The aims of the team were to identify, treat, and protect the child victim. However, much of the team's work was devoted to teaching and supporting the abusive parents. Despite the use of the hospital-based team in this approach, ultimate case management remained with the social workers from the Children's Aid Society, an agency similar to the Child Protective Services or Child Welfare Departments utilized in the United States.

In contrast to the short-term management approach of the Children's Hospital in Ottawa, a Florida project directed at child maltreatment directed its efforts to direct crisis intervention and long-term involvement. This hospital-based, multidisciplinary team was developed as an independent pilot project funded by the Florida Department of Health and Rehabilitative Services to address the coordination of services for child abuse and neglect.[23] Whitworth and his associates, who designed and implemented this project, included an evaluation component in the project objectives. Known as the Children's Crisis Center and located within the department of pediatrics of a major metropolitan hospital, the team included six pediatricians, two psychologists, an attorney, a consulting nurse-educator, and five case coordinators (two with degrees in nursing and three with degrees in social work), and a secretary. The reason for having the team in

the hospital was the accessibility it provided both to community screening, intake, and supervision workers and the physicians and other health care providers. Although this team approach was not new, Whitworth and his colleagues emphasized that the project represented a significant departure from traditional programs in order to better meet the needs of the families and to deal with the problem of underreporting.[24] The Children's Crisis Center was developed with a philosophy clearly identified as consultative and supportive. The team was to act as coordinators of case management rather than case managers. The case management was to reside with the various primary providers including physicians, intake workers, schoolteachers and the like. Because the team was funded for full-time, twenty-four-hour service, crisis intervention was a major commitment. However, the authors emphasized that if crisis intervention was the only service provided, then the family dynamics which led to the problem would not change. Alternately, if the team was responsible for full treatment and preventive services, then the caseload would be too broad and unwieldy. Thus, the approach taken was one of not only team assistance to the primary providers at the time of family crisis, but also the upgrading of the skills and services of these other professionals in managing the care of abusive families. In this way the services to families were expanded without necessarily increasing the number of professionals required.

Whitworth also emphasized that the team did not supplant the normal system of reporting and investigation but acted as an adjunct by providing the following services:

1. Round-the-clock consultation to health professionals as to whether abuse/neglect should be suspected and information as to reporting.
2. Diagnostic and evaluative services to physicians in suspect cases.
3. Consultative diagnostic and evaluation services to protective service workers for children who have been detained.
4. Consultative services to hospitalized children.
5. Consultation to caseworkers, health professionals, and others for case preparation, treatment plans, and placement alternatives.
6. Recommendations to parents as to treatment alternatives.
7. Consultation to legal systems and mental health facilities regarding child abuse and neglect.
8. Prolonged medical and psychosocial consultation to primary care providers in complex cases.
9. Follow-up facilities for eligible clients for medical problems and for monitoring treatment programs for family members.
10. Educational resources for all groups involved in the care of abused and neglected children.
11. Impetus for development and expansion of services alternative to placement of the child including lay therapists, crisis nurseries, and homemaker caretakers.
12. Liaison with other community agencies.[25]

An important concept utilized by the Children's Crisis Center was that of "role blurring." Team members were recruited on the basis of their ability not only to communicate with their colleagues and providers outside the team but also their ability to be flexible in their roles and to

accept the importance of other professionals dealing with families in crisis. Implementation of this concept required careful selection of team members and formal, intensive, interdisciplinary training of selectees.

During the first year of operation, the Children's Crisis Center was able to significantly improve the reporting rate of child abuse and neglect by health care professionals. The improved rate was attributed to the medico-legal support and feedback provided by the team to the reporting provider. The Children's Crisis Center program, although hospital-based, remained independent of both institution and community agency control. Although the authors do not specifically state that this independence was the key to their success, it appears that the freedom from bureaucratic control allowed the team to coordinate their services effectively.

The importance of total community involvement in establishing a child abuse/neglect treatment program was underscored by Sefcik and Ormsby in their description of a project based in a five county rural area of Indiana.[26] Project Children, as the program was named, developed out of a community-centered awareness of the difficulties of obtaining help for victims of child abuse and their families. Prior to program implementation, the issues of funding, priorities, politics, ignorance, professional and lay communication, and scarce resources were addressed by interested community representatives. While a regional mental health center

served as the coordinating agency for the program and obtained the needed grant funds, representatives from each county's Department of Welfare were the prime movers in assuring a cooperative approach in each community. Child Abuse Councils in each county worked with their respective welfare departments to: (1) achieve visibility; (2) become acquainted with influential persons and local power structures in order to use these as change agents; and (3) determine community attitudes toward child abuse and neglect, program innovation, and reporting responsiility.[27] Laying the groundwork to develop community awareness and cooperation early on prevented the kind of resistance generated when professionals dictate community needs. The hospital's role in this project was to provide child protection teams to investigate hospital-referred cases of child maltreatment and to provide medical consultation to the Welfare Department's child protection workers. The hospital teams developed the reporting protocol and obtained hospital administrative/board approval to use it. The teams were also given responsibility for evaluating the information obtained in the investigation of the individual cases. The evaluation included a family social history, a medical examination of the child victim, and a psychological evaluation of the parents/child. Hospital team review was very responsive, usually taking place within two to three days after the initial referral. The protocol for team review included answering four questions: (1) Is this a case

of child abuse/neglect? (2) Is guardianship necessary to protect the child? (3) Should the child be removed from the home? (4) What is the treatment plan that should be implemented and by whom?[28] The resulting recommendations were then forwarded to the Welfare Department for implementation. Other components of the regional project included a volunteer parent aide program to provide support to abusive parents, a community awareness and education program, and a preventive program to provide parent effectiveness training in the region.

Cunningham, in discussing hospital child abuse policies and procedures, states that hospitals should follow the goals outlined by the National Center on Child Abuse and Neglect in developing their programs.[29] These goals are to:

> 1. Identify children seen in the hospital who have been neglected or abused.
> 2. Provide adequate medical care to victims.
> 3. Report child abuse and neglect in accordance with state law.
> 4. Collect data so that adequate documentation will be available if needed in court.
> 5. Be therapeutic and helpful to parents, so that they will be receptive to long term treatment if needed.[30]

Cunningham echoes other professionals in specifying a team approach in the hospital. She also states that a social worker should act as liaison with local and state agencies. Of special note in this article is Cunningham's emphasis upon a joint approach by nursing, social work, administration, and

medical staff in the development and implementation of hospital policies and procedures regarding child abuse and neglect. Education sessions for hospital staff are a mandatory part of the hospital program with child protective service workers at each session in order to foster better communication between the hospital and the community agencies. Finally, Cunningham places increased responsibility upon the hospital social worker to act as the two-way communication bridge between the hospital staff and the child protective agency. Without feedback on case outcomes, the hospital staff members are likely to become frustrated and dissatisfied with their role in the program.[31]

Kerns, Cavanaugh, and Berliner suggest some other program areas for hospitals to develop in addressing the problem of child maltreatment.[32] These include programs to enhance parental bonding with their newborns, early identification of families in need of services using specific screening criteria, and expansion of prenatal classes to include parenting education. These authors also underscored the need for inservice education of hospital staff and the involvement of health professionals in advocating for the family in the various local and state political bodies and agencies that make policy decisions on social services, health services, housing, and education.

In terms of the military/civilian interface regarding child maltreatment, Broadhurst and associates state that it

is essential that the military and civilian agencies coordinate their services to enhance rapid intervention and to prevent duplication of services.[33] According to the authors, no one model is appropriate for every military installation because of the variations in the civilian agencies and the jurisdictional issues in the federal and local judicial systems. No matter what issues are involved, the authors continue to stress the importance of working out specific written agreements and procedures between the military and civilian communities with regard to medical, legal, and social services intervention. This requires a cooperative effort not only with the civilian protective service agencies and civil courts, but also between the medical facility commander and installation commander.

All authors reviewed in the literature search emphasized the importance of program evaluation as essential to child abuse/neglect program development. Whitworth and associates designed the Children's Crisis Center project to include evaluation components.[34] Simplified, computer compatible, data base documents were developed which would provide for collection of the information required for cost/benefit analysis without becoming a paperwork burden upon the team members. Outcome criteria based on program goals were determined to be the best measure of effectiveness. The criteria used were: (1) Fewer recurrences of child abuse in families reported to the team; (2) Fewer initial foster care

placements for abused children; (3) A decrease in foster care placement time for children involved with the team; (4) A decrease in judicial proceedings; and (5) Increased reporting by health professionals.[35]

The use of program outcomes as an evaluative measure is underscored by other authors. However, expected outcomes must be defined prior to program implementation. Sundel and Homan suggest the following elements be used in developing child abuse preventive activities: (1) Definition of the problem to be addressed; (2) Identification of the population at risk for the problem; (3) Measurement of the incidence of the problem in the population; (4) A clearly defined plan of intervention applied to the identified population; and (5) Measurement of incidence following the intervention.[36] In addition to the above elements which can be useful in measuring program impact, Sundel and Homan also suggest assessing the level of citizen awareness of services for child welfare and evaluating client satisfaction with services. Sundel and Homan address the significant problem of insufficient resources for program development by proposing the use of the medical concept of triage in which service is based on the individual's potential to benefit. Again, information regarding community attitudes and cost effectiveness should be utilized to determine which of many alternative approaches would provide the greatest benefit to the greatest number.[37]

Cohn, Ridge, and Collignan in their federally funded evaluation of eleven demonstration treatment projects for child abuse and neglect utilized five major components: (1) Goal determination and attainment to assess outcomes; (2) Process analysis to determine implementation problems and to develop quality standards; (3) Cost analysis to measure efficiency; (4) Client impact to determine effectiveness; and (5) Community systems assessment to determine awareness and coordination of the treatment projects with key community agencies.[38] Unfortunately, the authors did not indicate any of their preliminary findings regarding their evaluation program. However, the components mentioned could be a starting point for evaluation of any child abuse/neglect project.

Evaluation results have been published regarding some military child abuse/neglect programs. In his retrospective case analysis of military families reported to the Child Protection and Case Management Team at Fort Lewis, Washington, Lanier found that although there were similarities and differences in various factors, military parents did not have a higher rate of abuse than their civilian counterparts.[39] However, Lanier also found that the military community needed more effective liaison, coordination, and communication within the service units and agencies and with the civilian community. Project CARE (Child Advocacy Resources Expansion), funded in 1975 by the Department of Health, Education and Welfare as a research and demonstration project, sought

to demonstrate the effectiveness of a cooperative military/civilian approach to child abuse in the San Antonio, Texas area.[40] The project examined a wide range of issues including incidence rates, referral sources, demographic data, family stress factors, service delivery response times, military/civilian agency interaction and cooperation, factors in case disposition, services provided, obstacles to service delivery and coordination, and command involvement including the impact of child abuse reporting on the military sponsor's career. Of special interest in this study was the use of the prospective method of following cases by initiating review at the time of first reporting. The reason for selecting prospective review was the poor results of a previously conducted retrospective study. The retrospective study was hampered by the limitations, inconsistencies, and omissions in social service records; the existence of multiple records in the many agencies involved in treatment; and the lack of a central military/civilian case registry.[41] Because of the prospective nature of the review, Project CARE was able to obtain the needed information from the various case records. However, the author stressed the fact that this method is very time-consuming. One finding of the study was that the coordinated multidisciplinary effort is needed because the problems of child abuse in the military and civilian community are symptomatic of larger family dysfunction.[42] No one agency can adequately manage all these problems. Another

finding was that a large proportion of the families refused treatment. Outreach efforts by social workers seemed to be the most successful in convincing families to accept treatment. Another need discovered in Project CARE was the requirement for twenty-four hour-social work coverage to provide appropriate intervention at the time of crisis.

Wardinsky and Kirby utilized retrospective analysis in their study of the child protective program at David Grant USAF Medical Center, Travis Air Force Base, California.[43] The review consisted of two parts. One was epidemiologic data collection related to type of maltreatment, incidence, and characteristics of the families. The second part consisted of quantifying the quality of social service and medical management. The following four standards, required by the Child Advocacy Committee regulation, were used to evaluate each case: (1) Adequate identifying information; (2) Documented quarterly review; (3) Appropriate use of both military and civilian resources; and (4) Documented long-term management. Unfortunately, the authors did not provide the data retrieval definitions used for each of these standards. The results of the review of 158 cases from 1975 through 1977 were not surprising. The highest reported incidence was for physical abuse and the lowest was for sexual abuse with the incidence of neglect falling in between. The subjective quality of care review showed incomplete documentation, review, and follow-up in forty percent of the cases.

The only comparison study of military child advocacy programs discovered in this literature search was that reported by the General Accounting Office (GAO) to the U.S. Congress in 1979.[44] The GAO review included ten military services' child advocacy programs. In addition to discussing the programs with officials in the Offices of the Surgeons General of the Army, Navy, and Air Force and the Office of Assistant Secretary of Defense, the GAO study group consulted with "experts" in the area of child maltreatment in order to identify the essential elements of a child advocacy program.[45] The GAO report lists these elements as prevention and identification, intake and assessment, treatment, follow-up, and reporting. Criteria developed from these elements were used in assessing the local child advocacy programs at the ten installations. However, the published GAO report neither specifies these criteria nor does it outline the methodology used in data collection. This is a serious deficiency in the report because it prevents other researchers from using the criteria either to duplicate or refute the findings. The GAO report only states that the study group met with officials at the installations and also with officials at the civilian social welfare agencies in California and Texas. The GAO group also spoke with officials at the National Center on Child Abuse and Neglect (a Department of Health and Human Services agency) and officials from Project CARE.

Findings of the GAO study were numerous. However, a major finding was the lack of Department of Defense (DOD) guidance for the programs. This lack, according to GAO, resulted in inconsistencies in the services' child advocacy programs. Another problem highlighted was the lack of direct funding, and consequently, adequate staff at the installation level. The GAO also reported that central registry reporting systems in the services were inconsistent and ineffective for use in case management. GAO recommendations were also numerous. However, the major recommendation was that the Secretary of Defense take responsibility for program management rather than just program monitoring. Centralizing program management in DOD would, according to GAO, increase consistency in program policies, organization, and management between the military services. GAO also recommended providing more resources at the installation level. Centralization of program management at the DOD level would also be used to develop a single DOD policy on collection and reporting of cases by all the services.

The major result of the GAO report, so far, has been the issuance of DOD Directive 6400.1 on the Family Advocacy Program in May 1981. This directive establishes the DOD level Family Advocacy Program and Family Advocacy Committee with representatives from all the services, both line and staff commands, from DOD Health Affairs and Manpower, and from DOD Reserve Affairs and Logistics.[46] Another major

change is the formal requirement to include spouse abuse in the program. The directive places policy establishment and resource allocation under the Secretaries of each military service. While the elements of the directive suggest a single, more coordinated approach to Family Advocacy and a loosening of legislative jurisdiction which impedes military/ civilian coordination of case management, the full implications for the local command are not evident as yet.

Sexual Assault/Rape

Because of the need to gather legal evidence, the hospital is frequently involved in cases of reported sexual assault or rape. However, the literature reviewed seems to suggest that health system intervention varies from simply providing initial physical examination to coordinating long term care and follow-up. The increase in the number of reported sexual assaults, including sexual abuse and rape, has heightened public attention to the problem and intensified the need for coordinated medical, legal, and social programs to deal not only with the needs of the victim, but also to develop methods to prevent occurrence.[47]

One program to address the problem of sexual assault is described by Schneider, Blydenburgh, and Craft.[48] Organized as a unit of the Newark, New Jersey Police Department, the Sex Assault Rape Analysis (SARA) program was developed to provide support, sympathy, and advice throughout the

ordeal of reporting, obtaining treatment, and pressing charges for sexual assault. One component of the program was a medical treatment unit, established at a local hospital, for examining, treating, and obtaining medical evidence from the victim. While treatment of the victim and arrest and prosecution of the offender were important objectives of the SARA program, a major goal was to obtain epidemiologic data which could be used in developing adequate preventive programs in the community. The authors presented their findings which indicated that sexual assaults occur most frequently in the victim's home with both victim and assailant apt to belong to the younger age groups.[49] As a result of their findings, the authors believe that sexual assault needs to be addressed as a social problem particularly in terms of decreasing the social stigma attached to victims which prevents them from reporting the incident.

The multidisciplinary/interdisciplinary approach for sexual assault programs as for child abuse programs is well-documented in the literature. Evrard and Gold, in their description of the sexual assault program at Women and Infants Hospital of Rhode Island, state that medical, paramedical, and legal personnel must establish liaisons if the physical and emotional needs of the victim are to be addressed in a comprehensive manner.[50] To this end, the committee formed at this hospital included medical personnel, social workers, rape crisis peer counselors, the medical examiner,

the police, the Attorney General's office, the judiciary, and a legislator.[51] The committee provided a forum for discussion of mutual problems in case management and also developed a medical treatment protocol to be used in the care of victims. After a one-year study of the program, Evrard and Gold found that the following program needs still existed: (1) Integration of trained and empathetic health professionals and legal personnel; (2) Strict adherence to the patient care protocol in treating victims; and (3) Development of an effective system of follow-up of each victim to assess positive and negative results of the program.[52]

Some of the problems in adequately treating sexual assault victims are outlined by Hicks in her discussion of the Rape Treatment Center at Jackson Memorial Hospital in Miami, Florida.[53] The hospital uses a team concept with team member selection based upon sensitivity to the problems of rape victims. The team consists of gynecologists, emergency room nurses, and a crisis-trained social worker. One problem mentioned by Hicks is the fear and reticence of the victim to become involved in prosecution of the perpetrator of the sexual assault. At the Rape Treatment Center, the victim is not required to report the attack to the police. However, in those situations, the Center files an anonymous report to police since rapists often operate frequently and use the same mode of operation. At Jackson Memorial Hospital, sexual assault victims are treated in a separate unit

because the confusion of the emergency room places an additional stress upon the patient. Also, the emergency room is geared to treating life-threatening physical trauma rather than the serious psychological damage attendant upon a sexual attack. Only eight percent of the rape victims at Jackson Memorial Hospital had physical injuries with only one percent injured seriously enough to require hospitalization.[54] It is easy for such victims to be lost in the triage priorities of the typical emergency room. The problem of severe emotional trauma must be recognized immediately by trained counselors so that examination and interviews are conducted with a non-judgmental, protective attitude toward the sexual assault victim who has experienced the "ultimate invasion of privacy" for which he/she is ill prepared to deal.[55] Sensitive handling at the time of initial crisis intervention is more likely to result in victim compliance with follow-up counseling. Hicks stresses that such counseling must be arranged when the victim first presents at the treatment center.

The psychological needs of the sexual assault victim and the limited resources of a general hospital to provide the required emotional assistance to victims were addressed by the use of trained volunteer counselors in the Rape Crisis Intervention Program at Beth Israel Hospital in Boston.[56] Counselors are all health professionals from the disciplines of psychiatry, social service, psychology, and nursing.

Crisis intervention techniques and follow-up counseling methods are taught on a weekly basis. A counselor is available on a twenty-four-hour basis to victims presenting at the hospital. The counselor stays with the victim throughout the emergency room procedures in order to provide emotional support and to establish a therapeutic relationship for follow-up counseling. Follow-up begins forty-eight hours after the initial contact and continues at regular intervals for at least a year. If the need arises, the victim is referred to intensive psychotherapy. Although the counselors are volunteers, the hospital absorbs the cost in terms of time lost by the counselors from their regular staff duties.[57] According to McCombie and her associates, the program, although developed and backed by the Department of Psychiatry, included liaison with representatives from nursing, gynecology, emergency room, social service, and administration in order to obtain the cooperation of these departments. The authors are quick to point out that the volunteer counselor program is cumbersome and at times unreliable. However, the lack of resources to provide paid counselors has made the volunteer program the only realistic option available.

The need for a supporting individual to assist the rape victim through the tedious and aversive procedures of emergency room care is often answered by the use of either paid or volunteer professionals as in the previously mentioned program at Beth Israel Hospital. At Denver Hospital,

no such professionals were readily available so a program was developed utilizing trained lay persons as volunteer-companions to remain with and provide emotional support to the rape victim throughout the emergency room procedures.[58] Also, it was hoped that the volunteers would encourage the victims to report the crime. Since the program was directed at female victims of sexual assault, all volunteers recruitd were women. While authors Evans and Sperekas fully described the training for these lay volunteers, they could only report program success based on subjective observation because hospital policy precluded written records which might be subpoenaed for trial.[59]

Gottesman describes another area in which medical professionals can be involved with regard to intervention for sexual assault. Health professionals have provided training for police officers in intervention techniques with rape victims.[60] Programs, such as the one Gottesman describes, assist police officers in developing supportive attitudes which will encourage the rape victim to fully report the crime and to press charges against the perpetrator.

Unfortunately, most programs described in the literature are directed only at the female victim of sexual assault. There is increased indication that while male victims are less likely to report a sexual attack, the emotional trauma which results may be just as severe as for the female victim.[61] Similar attempts to hide the sexual component

of attacks are found in cases of abuse of children, especially when incest is the main factor.[62] Thus, health professionals can easily miss these problems when dealing with the other medical symptoms presented by the victim.

Spouse Abuse

The problem of spouse abuse seems to have generated the least amount of attention by the medical community. Review of the literature indicates that programs to support battered wives have been organized through women's groups or organizations such as the YWCAs without involvement or assistance from the health care community. In fact, Stark, Flitcraft, and Frazier found in their study of victims of domestic violence that physicians often treat victims' symptoms and ignore the underlying problem of battering.[63] According to this study, physicians identified only one out of thirty-five emergency room patients as victims of battering when correct identification would have approximated one in four.[64] Another problem, cited by the authors as resulting from incorrect medical understanding, is the dangerous practice of prescribing tranquilizers or pain medication to these victims of domestic battering because these patients have been shown to be at greater risk for suicide than victims of violence by strangers. By only recognizing the secondary problems of depression and substance abuse, the medical community, according to Stark and his associates,

disposes of battering as a psychiatric problem for the victim alone.[65] The findings of the authors do not present a very positive picture of the health care community in terms of assisting the battered woman. However, their findings do provide some clues as to the reasons for the lack of organized hospital programs to assist the spouse abuse victim. Private shelters and women's groups still provide the greatest resource for these victims both in obtaining medical care and in seeking legal protection from the abuser.[66]

Research Methodology

Overview

The lack of explicit standards developed by BUMED for evaluating the local Family Advocacy Programs required that standards considered to be implicit in the BUMED instruction be used in answering the research question. The methodology developed was based upon the evaluation techniques suggested in the literature and also upon those described in Development of Professional Standards Review for Hospital Social Work, published by the American Hospital Association. In addition, strategies for quality assessment outlined in BUMED Instruction 6320.62, Health Care Quality Assurance/Risk Management Program were utilized in designing the research techniques.

Objectives

While the main objective was to answer the research question, several secondary goals were also included in developing the research methodology in order to present a comprehensive study of the NRMC Camp Pendleton Family Advocacy Program, and to indicate problem areas with appropriate recommendations for program improvement. The goals, then, of this research were to:

1. Analyze the hospital's Family Advocacy Program to see if it met the guidelines and requirements of the BUMED instruction and determine the cause or reasons for areas of non-compliance.

2. Determine if the local Family Advocacy Program was effective in intervention and treatment of victims of suspected or established cases of abuse, neglect, sexual assault, and rape.

3. Determine if reporting of incidences of suspected abuse, neglect, sexual assault and rape was adequate.

4. Determine if both health care personnel and the beneficiary population, in general, were adequately educated and informed about the program.

5. Analyze the current cost of the local Family Advocacy Program.

6. Identify problems with the Family Advocacy Program and suggest methods of resolution.

Included in each section of the research was information not considered necessary for answering the research question but added to meet the secondary objectives. Each

specific part of the research, including the measurement criteria utilized, is described separately in the following sections.

Program Structure

A forty-six item listing was developed utilizing structural components extracted from the BUMED instruction on the Family Advocacy Program. Each item was investigated at the local level to determine whether or not it was a component of the local Family Advocacy Program. The item listing was not considered to be all inclusive, but contained what the researcher considered major components and what the researcher assumed to be a sufficiently large sample of the total structural items available. All documents related to the local Family Advocacy Program, including local instructions, written procedures, and plans, were searched to identify the presence of each of the forty-six structural items. Hypothesis testing at the 0.05 level of significance was used to determine if the proportion of structural items found to be present in the local program represented a majority or more than fifty percent of the total structural items sampled. If the results showed that a majority of the sampled structural items were present, the BUMED Family Advocacy Program would be considered as implemented locally in terms of structure.

In addition to the description of the item itself and its presence or absence, data collection included in what

document the item was found and any qualifying information such as reasons, provided by the local Family Advocacy Representative, for partial compliance or non-compliance. The Structural Item Tool used for data collection is provided in Appendix C.

Program Outcome

A data collection tool, presented in Appendix D, was developed to measure program outcomes. The goal of this data collection was two-fold:

1. To determine outcome measures of the success of the Family Advocacy Program in terms of identification of cases of neglect, abuse, sexual assault and rape in terms of compliance of victims and families with the established treatment program.

2. To obtain descriptive data about the reporting and treatment of cases of abuse, neglect, sexual assault and rape in a large military population which might be useful in determining the direction and management of the local program.

Family Advocacy Program files were reviewed retrospectively for the two year period from 1 January 1980 to 31 December 1981. Only those files designated as suspected or established maltreatment were reviewed. Data collected was analyzed using descriptive statistics for each item. Two outcome measures were utilized in the review. The first outcome standard, that of successful identification of cases of neglect, abuse, sexual assault and rape, was considered to be positively met if the incidence rates measured in the local

program matched or exceeded those in the general population. Hypothesis testing at the 0.05 level of significance was used to determine if the local rates met or exceeded those rates reported in the general population. The second outcome standard, that of compliance of victims and families with the established treatment programs, was considered to be positively answered if, in a majority of cases, the treatment plan was followed. Hypothesis testing at the 0.05 level of significance was used to support or reject the hypothesis that the results represented a majority. Both outcome standards had to be met in order to answer the research question positively.

The remainder of the data was collected to meet the second goal of providing information which would be useful in program operation and management and, in conjunction with data from the other segments of the research methodology, would provide a complete description of the local Family Advocacy Program.

Program Process

In order to evaluate the local Family Advocacy Program in terms of whether or not the required BUMED procedures were followed, the local files opened between 1 January 1980 through 31 December 1981 were reviewed and scored against five criteria developed from the stated requirements in the BUMED instruction. Only those files identified as suspected

or established maltreatment were included in the process review. The files were matched against each criterion with one point awarded for the presence of the criterion. Thus, a file meeting all five criteria was awarded the full five points. Hypothesis testing at the 0.05 level of significance was used to determine if a majority of files reviewed had a score of three or better on the process review. A majority scoring of at least three was required to answer the research question positively in terms of program process. The tool used in accomplishing the process review is provided in Appendix E.

It must be noted here that the reason only files identified as suspected or established maltreatment were reviewed in both the outcome and process measures was because it was only in these cases that the BUMED instruction required a treatment plan and follow-up.

Professional Awareness of the Family Advocacy Program

Because the BUMED instruction stressed the importance of professional awareness to facilitate reporting and instill a treatment philosophy, this section of the research was designed to determine whether or not hospital staff had received information regarding the Family Advocacy Program. A six-item questionnaire with appropriate cover letter was developed with item numbers 3, 4, and 6 utilized to score the local program in terms of professional awareness. The cover

letter and questionnaire are presented in Appendix F. If a majority of the respondents answered affirmatively to at least two of these items, the research question was considered to be answered positively in terms of professional awareness. Hypothesis testing at the 0.05 level of significance was used to determine if the results represented a majority of respondents.

The population for the survey sample was the military staff of the NRMC Camp Pendleton. An assumption of this section was that if the military staff was aware of the Family Advocacy Program, then the civilian employees would also be aware of the program. The sample size was estimated, utilizing standard methods, as shown in the following calculations:[67]

Equation: $$n = \frac{Nz^2pq}{d^2\ (N - 1) + z^2pq}$$

n: Sample Size N: Population Size (986)

P: Estimate of true proportion in population aware of the Family Advocacy Program. Since this estimate is unknown, 0.5 was used to obtain the largest sample necessary for a reliable sample.

q: $1 - p = 0.5$

z: Value to be used for a 95 percent confidence interval.

d: The acceptable width of the difference of the sample proportion from the true population proportion. In this case, plus or minus 0.05 was used.

Utilizing the formula and values shown, a sample size of 277 staff was obtained. A random listing of 300 staff members was generated by entering random numbers into the hospital computer. These military staff members were sent the questionnaire with a request to respond in one week. Each questionnaire was numbered so that identity of respondents was known only to the researcher. The numbering system was also used to facilitate second requests to non-respondents.

Items numbered 1, 2, and 5 were included to obtain descriptive data of respondents and to obtain some information as to staff attitudes about the role of the hospital in Family Advocacy.

Public Awareness of the Family Advocacy Program

The BUMED instruction specifically mentions public education as a program component. In order to assess the local Family Advocacy Program for meeting the requirement, a brief questionnaire consisting of seven items was developed. A sample of the survey tool is provided in Appendix G. Items number 5 and 6, respectively, were used in the measurement of public awareness. At least one of these two had to be answered positively by a majority of the respondents in order to award a positive mark in the public awareness component of the Family Advocacy Program. A sample size of 384 was determined based upon the desire to estimate the true population

proportion within 0.05 percent with 95 percent confidence. Since the true population proportion was unkown, a proportion of 0.5 was used to give the largest sample size necessary for reliable estimation. Only adult beneficiaries, including retired and active duty members and spouses, were included in the survey. The questionnaire was distributed and collected at entry points in the ambulatory care area of the core hospital.

Hypothesis testing at the 0.05 level of significance was used to determine if positive survey responses represented a majority or greater than fifty percent of the sample. The remaining five items on the questionnaire were used to provide demographic data and to assess public willingness to utilize family-type medical services for social problems.

Interviews with Family Advocacy Committee Members

While this section of the research was not considered necessary to answer the research question, it was decided that the research would not be locally valuable unless information was obtained about the perceptions and opinions of those tasked with involvement in the Family Advocacy Program. A semi-structured interview, mainly involving program effectiveness, was conducted with each member of the Family Advocacy Committee and sub-committees utilizing the interview tool presented in Appendix H.

Cost of the Family Advocacy Program

In order to provide a complete picture of the local Family Advocacy Program, an assessment of the cost of the program was obtained and examined. Utilizing data from the hospital budget and Uniform Chart of Accounts input data, a brief analysis of cost versus benefits was conducted to be presented in conjunction with the results obtained in the other research components.

Chapter I Notes

[1]U.S., Department of Health and Human Services, National Center on Child Abuse and Neglect, Child Protection in Military Communities, by Diane D. Broadhurst et al, DHHS Publication No. (OHDS) 80-30260 (Washington, D.C.: Kirshner Associates, 1980), p. x.

[2]Evelyn Millis Duvall, Family Development, 2nd ed. (Philadelphia: J.B. Lippincott Company, 1962), p. 66.

[3]U.S., Department of Health and Human Services, National Center on Child Abuse and Neglect, Child Abuse and Neglect Among the Military, by Richard Roth, DHHS Publication No. (OHDS) 80-30275 (Washington, D.C.: Herner and Company, 1980), p. 3.

[4]Lisa G. Lerman, Legal Help for Battered Women (Washington, D.C.: Center for Women Policy Studies, [1980]), p. 1.

[5]U.S., Department of Health and Human Services, Child Abuse and Neglect Among the Military.

[6]Ibid.

[7]Ibid, p. 1.

[8]Edna J. Hunter and D. Stephen Nice, ed., Children of Military Families, a Part and Yet Apart (Washington, D.C.: Government Printing Office, 1978), p. vii.

[9]Robert D. McCullah, "Effects of Family Dysfunction on Military Operations: Mental Health Needs", in The Military Family and the Military Organization, ed. Edna J. Hunter and Thomas C. Shaylor (San Diego: United States International University, 1979), p. 33.

[10]Hunter.

[11]U.S., Department of Health and Human Services, Child Abuse and Neglect Among the Military.

[12]Ibid.

[13]Ibid., p. 4.

[14]Ibid.

[15]U.S., Congress, General Accounting Office, Military Child Advocacy Programs--Victims of Neglect, by the Comptroller General, HRD 79-75, 1979, p. 5.

[16]Ibid., p. 7.

[17]Adapted from U.S., Department of Health and Human Services, Child Protection in Military Communities, pp. 42-7, and U.S., Department of the Navy, Bureau of Medicine and Surgery, Family Advocacy Program, Instruction 6320.57, 1979.

[18]U.S., Department of Health and Human Services, Child Protection in Military Communities, p. 46.

[19]Statistics are based upon preliminary DEERS estimates from Fiscal Year 1980 and local hospital-generated estimates.

[20]McCullah, p. 34.

[21]Robert S. Nichols, "The Military Family/Military Organization Interface: A Discussion", in The Military Family and the Military Organization, ed. Edna J. Hunter and Thomas C. Shaylor (San Diego: United States International University, [1979]), p. 64.

[22]Lynda Fitzpatrick, "A Team Approach to Child Abuse", Canadian Nurse 75 (January 1979):37.

[23]Jay M. Whitworth et al, "A Multidisciplinary, Hospital-Based Team for Child Abuse: A 'Hands-on' Approach", Child Welfare 60 (April 1981):234.

[24]Ibid.

[25]Ibid., p. 238.

[26]Thomas R. Sefcik and Nancy J. Ormsby, "Establishing a Rural Child Abuse/Neglect Treatment Program", Child Welfare 57 (March 1978):188.

[27]Ibid., p. 189.

[28]Ibid., p. 191.

[29]Louise Cunningham, "Child Abuse Policies and Procedures", Quality Review Bulletin 6 (September 1980):27.

[30]Ibid.

[31]Ibid., p. 30.

[32]David L. Kerns, Jane Cavanaugh, And Benjamin C. Berliner, "Child Abuse and Neglect: The Hospital's Expanding Role in Prevention, Identification, and Management", Connecticut Medicine 43 (May 1979):293.

[33]U.S., Department of Health and Human Services, Child Protection in Military Communities, p. 66.

[34]Whitworth, p. 234.

[35]Ibid., p. 236.

[36]Martin Sundel and Carolyn Clark Homan, "Prevention in Child Welfare: A Framework for Management and Practice", Child Welfare 58 (July-August 1979):518.

[37]Ibid., p. 518-9.

[38]Anne Harris Cohn, Susan Shea Ridge, and Frederick C. Collingnon, "Evaluating Innovative Treatment Programs in Child Abuse and Neglect", Child Today 4 (May-June 1975): 12.

[39]Daniel Lanier, "Child Abuse and Neglect Among Military Families", in Children of Military Families: A Part and Yet Apart, ed. Edna J. Hunter and D. Stephen Nice (Washington, D.C.: U.S. Government Printing Office, 1978), p. 117.

[40]Sandra Maley Schnall, "Characteristics and Management of Child Abuse and Neglect Among Military Families", in Children of Military Families: A Part and Yet Apart, ed. Edna J. Hunter and D. Stephen Nice (Washington, D.C.: U.S. Government Printing Office, 1978), p. 143.

[41]Ibid., p. 146.

[42]Ibid., p. 162.

[43]Terence D. Wardinsky and William Kirby, "A Review of Child Maltreatment at a USAF Medical Center," Military Medicine 146 (May 1981):328.

[44]U.S., Congress, Military Child Advocacy Programs--Victims of Neglect, p. 2-3.

[45]Ibid., p. 2.

[46]U.S., Department of Defense, Family Advocacy Program, Directive Number 6400.1, May 19, 1981, p. 2-3.

[47]D. Jean Schneider, Donald Blydenburgh, and Gail Craft, "Some Factors for Analysis in Sexual Assault", Social Science Medicine 15A (January 1981):55.

[48]Ibid., p. 55-6.

[49]Ibid., p. 60.

[50]John R. Evrard and Edwin M. Gold, "Epidemiology and Management of Sexual Assault Victims", Obstetrics and Gynecology 53 (March 1979):381.

[51]Ibid.

[52]Ibid., p. 387.

[53]Dorothy J. Hicks, "Rape: Sexual Assault", American Journal of Obstetrics and Gynecology 137 (August 1980):931.

[54]Ibid.

[55]Ibid.

[56]Sharon L. McCombie, et al, "Development of a Medical Center Rape Crisis Intervention Program", American Journal of Psychiatry 133 (April 1976):419.

[57]Ibid., p. 420.

[58]Hannah I. Evans and Nicole B. Sperekas, "Community Assistance for Rape Victims", Journal of Community Psychology 4 (October 1976):378-9.

[59]Ibid., 380.

[60]Sharon Tennstedt Gottesman, "Police Attitudes Toward Rape Before and After a Training Program", Journal of Psychiatric Nursing and Mental Health Services 15 (December 1977):14.

[61]Arthur Kaufman et al, "Male Rape Victims: Noninstitutionalized Assault", American Journal of Psychiatry 137 (February 1980):223.

[62]John A. Tilelli, Dianne Turek, and Arthur C. Jaffe, "Sexual Abuse of Children", The New England Journal of Medicine 302 (February 7, 1982):322.

[63]Evan Stark, Anne Flitcraft, and William Frazier, "Medicine and Patriarchal Violence: The Social Construction of a 'Private Event'", International Journal of Health Services 9 (March 1979):461.

[64]Ibid., p. 467.

[65]Ibid., p. 471.

[66]Lerman, p. 12.

[67]Wayne W. Daniel, Biostatistics: A Foundation for Analysis in the Health Sciences, Second Edition (New York: John Wiley & Sons, 1978), p. 145.

CHAPTER II

DISCUSSION

Introduction

The data collection for the research on the Naval Regional Medical Center (NRMC) Camp Pendleton Family Advocacy Program (FAP) began in February 1982, and ended in April 1982. Despite the volume of information, data collection was successful in all sections with only minimal problems encountered by the researcher. To facilitate a complete understanding of findings, each component of the research was analyzed separately before any general conclusions were drawn. Presentation of findings in the same manner seemed the most logical format for this section. Consequently, only findings and results specific to each research component are presented in this chapter. General conclusions and recommendations were reserved for the final chapter of the project.

Structural Review of the NRMC Family Advocacy Program

In exploring the local program for the presence of the forty-six structure items, it was discovered that only nine sources of documentation existed (See Appendix C which contains the Structural Item Tool used for the data collection). These sources are listed in Table 1. Discussions

with the NRMC Family Advocacy Representative (FAR) prior to initiating the structure review yielded the information that no other sources of program documentation such as local policy, organization, or procedure manuals existed.

TABLE 1

NRMC DOCUMENT SOURCES FOR FAP STRUCTURE REVIEW

Document Numerical Designation	Subject	Date
NRMC Instruction 5420.8	Boards, committees and collateral duties	29 February 1980
NRMC Instruction 5800.3A	Medical Cases Involving Criminal Acts, reporting of	12 February 1980
NRMC Instruction 5800.4C	Child Advocacy Program	13 December 1979
NRMC Instruction 6120.3D	Management of Care of Alleged Sexual Assault Including Rape	not dated
NRMC Instruction 6320.27	Suspect and Established Spouse Abuse, reporting of	31 January 1977
NRMC Instruction 6320.29B	Spouse Abuse, procedures for processing	14 November 1979
None	Family Advocacy Program Committee and Sub-committee listings	February 1982
None	NRMC Plan of the Day	Issued daily

Comparison review of the documents listed in Table 1 with the Structural Item Tool showed that documented compliance with the Bureau of Medicine and Surgery (BUMED) Family Advocacy Program was evident with twelve of the items. Noncompliance, as substantiated by incomplete or non-existent program documentation, was found in thirty-four of the items. Incomplete documentation meant that an item was found in one local instruction, but, according to the BUMED Family Advocacy Program instruction, should have applied equally to child advocacy, spouse abuse, and sexual assault, and thus, should have appeared in all instructions.

Hypothesis testing at the 0.05 level of significance showed that the number of undocumented structural items was greater than fifty percent (p-value is less than 0.001). Thus, the BUMED Family Advocacy Program was not considered to be implemented locally in terms of program structure (The values for the hypothesis testing are presented in Appendix I). The structure items found to be present in local documents are presented in Table 2.

A review of the items in Table 2 suggested that the basic structural components were present in the local FAP. In addition to the three working committees required by the BUMED instruction, there were two other FAP sub-committees: (1) High Risk and (2) Education. While reporting of suspected incidents of abuse, neglect, or sexual assault to the FAR was required in all the instructions, reporting referred

TABLE 2

FAP STRUCTURE ITEMS PRESENT IN NRMC DOCUMENTS

Item Number	Item Description
2	A Family Advocacy Committee is established.
3	The FAC consists of the following members: Chairman, Lawyer, Pediatrician, Gynecologist, Psychiatrist or Psychologist, Chaplain, Dental Officer, Social Worker, Pediatric Nurse, Health Care Administrator, Alcohol Rehabilitation Service Representative.
6	There are three working committees of the FAC: Child abuse/neglect; Spouse abuse/neglect; Sexual assault/rape.
10	A Duty FAR is provided to handle incidents occurring after normal working hours.
11	The DFAR is designated by name in the Plan of the Day.
16	There is a system established for reporting cases diagnosed by working committees as "suspected" or "established" to Chief, BUMED.
19	There are established policies for emergency response to abused/neglected family members in imminent danger which include: Removal from the dangerous situation; Emergency medical care; Hospitalization; and Protective custody.
21	There are specific policies for the care, evaluation and full medico-legal documentation of cases of alleged or suspected sexual assault and rape which are consistent with BUMED requirements.
22	There is local policy for reporting all incidents of possible abuse, neglect, sexual assault, or rape to the FAR or DFAR.
25	There is a local policy to provide for medical care to abuse victims when parental/sponsor authorization is withheld or unavailable.
31	Guidelines are established for the FAR or DFAR in obtaining the initial clinical interview with the victim.
33	Privacy Act restrictions are established for all interviews.

only to medical officers. There was no indication that other hospital personnel or agencies outside the medical center must also report incidents.

Nine items were found to be inadequately documented in the instructions. They were considered to be inadequately documented because they appeared in only some of the instructions or were limited in scope. This suggested that the items did not apply equally to each program component. Table 3 presents a classification of the items judged to be inadequately documentd by the program instructions in which they did appear. Only item numbers are provided in Table 3 (See Appendix C for the description of each item).

TABLE 3

CLASSIFICATION OF INADEQUATELY DOCUMENTED FAP STRUCTURAL ITEMS

BY PROGRAM INSTRUCTION IN WHICH THEY DO APPEAR

Item Number	Child Abuse/Neglect NRMC Inst. 5800.4C	Spouse Abuse NRMC Inst. 6320.29B	Sexual Assault NRMC Inst. 6120.2D
1		x	
7	X		
8	X		
20	X		X
26	X		X
27	X		X
39	X		

Two structure items, numbers 28 and 30, were considered inadequately documented because involvement and assistance from other agencies was limited to legal intervention rather than the broader support and assistance required by the BUMED instruction. The problem associated with this inadequate documentation was that it had the potential for causing confusion in attempts by medical center staff to implement the provisions of the program as outlined in the applicable instructions.

Structural items found to be absent in the local program documents were discussed with the NRMC FAR. She indicated that some of these items were program policy but were not documented. She also provided reasons for the lack of the remaining structural items. Table 4 presents a summary listing of the missing structural items with associated comments gained from the discussions with the FAR. Again, only the item numbers are listed (See Appendix C for a complete description of the items).

While many of the absent structure items were followed as unwritten policy, the lack of documentation was determined to be a potential problem area for a number of reasons. First, unwritten policies provided too many opportunities for unequal application in case determination and management. Second, utilization of the BUMED instruction as the local policy and procedure document was considered impractical because not all staff have easy access to the manual.

TABLE 4

SUMMARY OF COMMENTS REGARDING STRUCTURE ITEMS ABSENT IN FAP DOCUMENTS

Item Numbers	Comments
4,5,13,14,15,24,38,46	Unwritten Policy or procedure.
9,17	Education of staff is handled on and individual basis as the need arises.
12,29,32	Impractical or unnecessary for local program.
18,35	Programs are being developed by the Education committee.
34	FAR remains outside case until legal implications are clear.
37	Information from collateral sources is obtained by Child Protective Service Workers only.
40,41,42	Use the BUMED instruction for guidance.
43,45	Require the old files for tracking recurrences.
44	Each facility uses different criteria for determining abuse and neglect. A letter is sent when a family transfers to another location.

Third, local instructions were found to be inadequate for policy guidance because they only referred to initial reporting and management without providing procedures to guide the

committees and sub-committees in their activities. Fourth, the BUMED instruction provided no criteria for determination of whether or not an incident was established maltreatment, suspected maltreatment, or unfounded. However, the local program did not develop and document its own criteria to guide committee decisions. The lack of written agreements delineating the working relationship between the hospital's FAP and the various military and civilian agencies was also a significant deficiency. Such agreements were needed because resources and legal requirements vary from one geographical location to another.

A well-developed staff education program was also noted as a deficiency in the local program because it could have been used to generate staff understanding and involvement.[1] Another method of achieving staff involvement would have been the rotation of the DFAR responsibilities among more than one professional group. The current practice of having only the Medical Service Corps officer, who stands the Officer of the Day watch, assume DFAR responsibilities limited the involvement of other staff members in key positions such as the Medical Officer of the Day and the Nursing Supervisor. However, the FAR indicated that rotation of DFAR responsibilities was impractical because of lack of knowledgeable staff.

Inadequate staffing in the Social Work Service was the major reason, according to the FAR, for the local

program's inability to comply with many of BUMED Family Advocacy structural requirements. Considering the multitude of program demands, this seemed to be true since it appeared that the Social Work Service was the only department tasked with the organization, implementation, and management of the Family Advocacy Program. Because of the deficiency of a fully documented framework for the Social Work Service, it was difficult to demonstrate the magnitude of the department's responsibilities. In fact, written procedures and policies are a requirement of the Joint Commission on Accreditation of Hospitals.[2] More importantly, the development of a documented local FAP structure would have demonstrated clear program objectives that would have provided guidelines for appropriate resource usage. In fact, with so many BUMED structural requirements, it is incumbent upon the local FAP not only to define program objectives, but also to prioritize them so that hospital staff devote their time and efforts first to those tasks of the greatest importance.

Review of Local Advocacy Program Outcomes

A review of program outcomes was conducted by auditing the Family Advocacy Program files opened between 1 January 1980 and 31 December 1982. A total of 482 records were reviewed using the Data Collection Tool shown in Appendix D. The distribution of the records among the main categories and the years covered is shown in Table 5.

TABLE 5

DISTRIBUTION OF FAMILY ADVOCACY FILES REVIEWED BY MAJOR CATEGORY AND YEAR OPENED

Major Category	1980	1981	Total
Child Abuse/Neglect	90	69	159
Spouse Abuse	152	151	303
Sexual Assault/Rape	10	10	20
Total	252	230	482

According to the Family Advocacy Incident Log, there should have been a total of 500 records of established or suspected cases in all categories. However, eighteen records were not present in the files, including six in the Child Abuse/Neglect category, eleven in the Spouse Abuse category, and one in the Sexual Assault/Rape category. It was decided these missing records could be ignored since they represented only four percent of the total population of five hundred records.

The first objective of this review was to measure the program outcomes in terms of identification of cases. In reviewing the literature, it was found that incidence rates for each of the three major categories are based upon reporting cases in the local program and those in the general

population seemed appropriate. Based on conservative figures for local populations served by the NRMC, the local incidence rates for each category were determined (Appendix J provides population estimates used). General population reporting rates for each major category were extracted from articles on the subject. Child abuse/neglect reporting rates, including sexual abuse of children, were 8.8 cases per 1,000 children.[3] This rate was based upon the 1970 census figures, but more current data was not found. Spouse abuse reporting rates were more difficult to determine because no state laws require a reporting format which would generate statistics. However, various crime and civil rights surveys have estimated reported spouse battering at 42 cases per 1000 couples.[4] In terms of sexual assault/rape, the Uniform Crime Reports, published by the Federal Bureau of Investigation, reported rapes was 5.2 cases per 10,000 female population.[5] Estimates for male sexual assault rates were not found, possibly because of what Kaufman and associates determined was a reluctance on the part of adult male victims to report such assaults or the general conception that sexual assault against men is an "aberration of prison life" or a violent component of the homosexual subculture.[6] Since only one male victim was found in local FAP case files reviewed, the lack of reporting rates for this sub-category had to be ignored. Table 6 shows the NRMC program rates for each major category and the rates found for the general population.

Since the highest rates for the local program were for the year 1980, these are the figures that were used in the comparison.

TABLE 6

REPORTING RATES BY CATEGORY FOR NRMC FAMILY ADVOCACY PROGRAM AND THE GENERAL POPULATION

Category	NRMC Rate	General Population Rate
Child Abuse/Neglect	5 cases per 1000 children	8.8 cases per 1000 children
Spouse Abuse	5 cases per 1000 couples	42 cases per 1000 couples
Sexual Assault/Rape	4 cases per 10,000 women	5.2 cases per 10,000 women

Hypothesis testing was used to determine whether or not local incidence rates met or exceeded those rates estimated for the general population (Hypothesis test values are presented in Appendix I). In terms of child abuse rates, it could not be proven at the 0.05 level of significance that general population rates were higher than those reported in the local program (p-value equals 0.3745). The same result was found with the sexual assault rates (p-value equals 0.484). Only in terms of spouse abuse were the local program rates found to be lower (p-value equals 0.0427). Since two out of three categories measured at least met general

population estimates, it was determined that the first outcome standard, that of successful identification of cases, was also met. It must be noted here that no general conclusions about incidence rates for abuse, neglect, or sexual assault in the NRMC Camp Pendleton beneficiary population should be drawn from the statistics presented. First, these are estimates based upon only cases reported to the Family Advocacy Program. The number of cases coming directly to the attention of civilian agencies was unknown. The rough comparisons used for the measurement were made only to answer the research question. To provide adequate comparisons between civilian and military population, case control and cohort studies would have to be conducted which matched similar population groups by controlling for the many factors involved.

Measuring the second outcome standard, that of compliance of victims and families with the established treatment program, depended first upon determining that a treatment plan was established and then finding out if it was followed. Each file was reviewed for documentation of these two factors. Table 7 shows the results of this section of the outcome review.

From the results of this review, it was shown that treatment plans were documented in the files for fifty-four percent of the cases. Forty-six percent did not have treatment plans documented. Of the fifty-four percent of the

TABLE 7

RESULTS OF REVIEW FOR TREATMENT PLAN ESTABLISHMENT AND VICTIM/FAMILY COMPLIANCE
(Number of Cases)

Category	Treatment Plan Established		Treatment Plan Followed	
	Yes	No	Yes	No
Child Abuse/Neglect	84	75	44	40
Spouse Abuse	165	138	58	107
Sexual Assault/Rape	13	7	8	5
Total Cases	262	220	110	152

total cases reviewed that had a treatment plan documented, forty-two percent of the files indicated that victims and families, as applicable, followed the treatment plan. Hypothesis testing at the 0.05 level of significance failed to show that this was a majority of the cases (p-value equals 0.0048). Thus, the second outcome standard was not met (Hypothesis test values are shown in Appendix I). Since only the first of the two outcome standards was answered positively, the research question was not answered positively on the outcome measure.

In making comparisons between the major categories in terms of raw data, it was apparent that compliance with

treatment programs was better in the reported child abuse and sexual assault cases. It was possible that in the child abuse cases, the pressure from the juvenile court on the families may have fostered the compliance. In the sexual assault cases, the only factor that was apparent was that the majority of victims were active duty. However, this research did not explore this factor as a reason for compliance. The reasons for the lack of establishment or at least documentation of a treatment plan also were not determined.

The remainder of the data collected in the outcome review was gathered to provide information which might be useful for program operation and management. Documentation for every data item was not found in every case file. For this reason, figures did not always add up to the total cases reviewed.

Child abuse/neglect data was collected from the 159 files reviewed. Data for the various categories of child abuse/neglect are presented in Table 8.

TABLE 8

CLASSIFICATION OF CHIILD ABUSE CASES AT NRMC

CAMP PENDLETON, 1980 and 1981

Classification	Number*	Proportion
Physical Abuse	102	60%
Sexual abuse	28	17%
Psychological abuse	3	2%
Physical neglect	36	21%

*N = 169, Some files involved more than one child in family.

The finding that the category of physical abuse showed the highest percentage was similar to findings of the studies reviewed in the literature.[7] The percentages of sexual abuse and physical neglect also compared almost equally with Air Force Office of Special Investigation statistics for 1976.[8] No comparison statistics were found for psychological abuse. The percentages for the file designations of established and suspected abuse were not presented because these were the only cases reviewed. Although the majority of files were designated as established, the criteria used to make this determination were not indicated in any of the records reviewed.

Average age of the abused children was three years, but ages ranged from two months to eighteen years. There were more abused female than male children, fifty-three percent and forty-seven percent, respectively. This is contrary to most studies which have shown male children to be at slightly greater risk for abuse at least below the teen years.[9] The identity of the perpetrator/abuser was documented in most cases and was classified into four major categories as presented in Table 9. It was obvious that parental abuse/neglect accounted for the largest number. The majority of sponsors were Marine Corps, not a surprising finding since the majority of the beneficiary population are in this service. Forty-five percent of the sponsors were active duty in pay grades E-1 through E-9. The active duty officer and

retired sponsor groups accounted for four percent each. Pay grade or rank designation was missing in eight percent of the files reviewed.

TABLE 9

CLASSIFICATION OF ABUSER/PERPETRATOR IN CHILD ABUSE/NEGLECT CASES AT NRMC CAMP PENDLETON, 1980 AND 1981

Classification	Number*	Percentage
Mother	49	29
Father	76	46
Other relative**	19	11
Person Outside Family	23	14

* N = 167, In some cases more than one abuser was implicated.

**Includes stepparents.

Spouse abuse cases reviewed also were categorized as to type of abuse. All 303 files reviewed in this category specified the type of abuse. Table 10 shows the results of this part of the review. Comparison figures for the different types of spouse abuse were not found in the studies reviewed. These studies discussed physical battering only. The high proportion of physical abuse found may have been due to the fact that this was the only type of spouse abuse to have received significant notice.

TABLE 10

TYPES OF SPOUSE ABUSE CASES AT NRMC CAMP PENDLETON, 1980 AND 1981

Category	Number of Cases	Percentage of Cases
Physical abuse	292	96
Psychological abuse	9	3
Physical neglect	2	1

Ages for battered spouses were documented in 294 of the 303 files reviewed. The victim age range was from 15 to 60 years old with a mean of 25 years. Sex of the victim was documented in ninety-five percent of the files. Females were the victims in ninety-four percent of the cases reviewed. When males were victims, it was most often in cases of mutual battering. The sponsor's rank was documented in ninety-six percent of the files. Results are shown in Table 11.

TABLE 11

RANK OF SPONSOR IN SPOUSE ABUSE CASES AT NRMC CAMP PENDLETON, 1980 AND 1981

Rank	Number	Percentage
E-1 to E-4, active duty	152	52
E-5 to E-9, active duty	118	41
Officer, all grades, active duty	11	4
Retired, all grades	9	3

As in the child abuse cases, the enlisted ranks accounted for the highest percentages of spouse abuse. However, given that officers account for only about seven percent of the total active population, these statistics cannot be used to indicate that enlisted families have a higher incidence of abuse and neglect.

In the twenty cases of adult sexual assault reviewed, only one victim was male. Even though the reporting rate for sexual assault was comparable to that in the general population, Kaufman suggested that this crime was severely underreported for both male and female victims.[10] The average age of the victims was 21 years with a range from 18 to 27 years. Seventy percent were active duty members and the remainder were spouses of active duty. The sponsor's rank was in the E-1 through E-4 pay grade in all cases. The assailant was identified in only two of the twenty cases reviewed. None of the twenty cases was determined to be established sexual assault. Perhaps this was because establishing that a crime has been committed is a legal rather than a medical determination.

Some of the other factors examined in the outcome review were analyzed for all categories combined. Referral sources from which the FAP received initial reports are shown in Table 12 by major file category. This item was documented in ninety-one percent of the files reviewed. With physical trauma the most common form of abuse noted, the finding that

the Emergency Room was the highest referral sources was not surprising. However, it did point up the need for emergency room personnel to be well-educated in how to manage these victims. As was already pointed out in the literature review, sensitive handling of these victims was considered necessary in order to encourage them to seek further assistance for their problems.

TABLE 12

REFERRAL SOURCES BY CASE CATEGORY FOR THE FAMILY ADVOCACY PROGRAM AT NRMC CAMP PENDLETON, 1980 AND 1981

Category	Number of Cases By Referral Source			
	Emergency Room	Military Police	Other Hospital Depts.	Outside Agencies Personnel*
Child abuse/neglect	40	31	23	51
Spouse abuse	187	36	30	20
Sexual assault/rape	11	8	0	0
Total	238	75	53	71

*Includes sponsor and self-referrals.

The low number of referrals from other hospital departments raised some doubts about the awareness of these services regarding detection and reporting of possible incidents of abuse, neglect, and sexual assault. Studies have

shown that such victims often present with other complaints and vague histories which may mislead the clinician into ignoring the possibility of abuse, neglect, or sexual assault.[11] Among the referrals from other hospital departments, the Alcohol Rehabilitation Service accounted for only eleven percent. This was surprising in view of the fact that alcohol use has been implicated frequently in domestic violence.[12] Perhaps policies relating to confidentiality of disclosures by clients in the Alcohol Rehabilitation Services prevented reporting or referral to the FAP.

Another factor reviewed was that of hospitalization of the victim. Table 13 provides comparison figures by category for the numbers of victims requiring hospitalization. This item was documented in ninety-three percent of the files reviewed.

TABLE 13

HOSPITALIZATION RATE OF VICTIMS BY FAMILY ADVOCACY PROGRAM CASE CATEGORY AT NRMC CAMP PENDLETON, 1980 AND 1981

Category	Number Hospitalized	Percentage Hospitalized
Child abuse/neglect (N = 148)	73	49
Spouse abuse (N = 282)	11	4
Sexual assault/rape (N = 17)	3	18

The high rate of hospitalization for child victims may have been due to the fact that some children were hospitalized for protective reasons rather than for the seriousness of their injuries. The relatively low rate of spouse abuse victims requiring hospitalization cannot be assumed to mean that most spouse abuse injuries were not serious. It may have been a representative of the problem that Stark and associates discovered in terms of inaccurate identification of the spouse abuse victim except when the victim admitted that the injury was non-accidental.[11] A review of medical records, such as that done by Stark and his colleagues, would be required to show whether or not spouse abuse victims were being properly identified.

Two other related factors were examined. One was the number of days from initial report of abuse, neglect, and assault to the next interview with the Family Advocacy Representative. The second was the number of days from initial report of the incident to diagnosis by the FAP working committee. Documentation of dates needed to determine these factors was not as high as for the factors already mentioned. The date of the next interview with the FAR was present in only fifty-one percent of the files reviewed. The date of the committee review of the case was documented in only fifty-seven percent of the cases. Table 14 shows the average number of days as well as the range for each of the categories for both factors.

TABLE 14

AVERAGE NUMBER OF DAYS FROM INITIAL REPORT OF INCIDENT TO INTERVIEW WITH FAR AND TO DIAGNOSIS BY COMMITTEE BY CASE CATEGORY, NRMC CAMP PENDLETON FILES, 1980 AND 1981

Category	Average days to FAR Interview	Average days to Committee Diagnosis
Child abuse/neglect	12 (range 0--30 days)	28 (range 1--411 days)
Spouse abuse	9 (range 0--96 days)	31 (range 1--240 days)
Sexual assault/rape	6 (range 0--15 days)	33 (range 6--72 days)

The reasons for the delays and lack of documentation both in the interview dates and the committees reviews of cases could only be surmised. In some cases, the victim and/or family may have refused the interview, failed to keep appointments, or could not be contacted. Committee schedules and lack of information may have delayed the case review. However, these delays did raise some questions about the program especially in terms of responsiveness to the victims. For example, were adequate methods used to make contact with the victims and families? Did the initial intervention at the time of first recognition of the incident encourage the victim/family to seek additional help from the FAR? If long delays in committee review of the case were the rule, was

committee review really necessary? These questions cannot be answered on the basis of the information gained in this research. However, the data did point to a deficiency in current program methods of initiating contact with the victims/families and determining status of cases.

The remaining two factors reviewed may, in fact, be related although no attempt was made to discover a correlation. The first factor was that of sources of treatment. Table 15 presents this data for each case category. Numbers do not equal total cases reviewed because, as already mentioned, treatment plans were not established or at least not documented in every file.

TABLE 15

SITE OF TREATMENT SOURCE BY NUMBER OF CASES IN EACH FAMILY ADVOCACY CATEGORY, NRMC CAMP PENDLETON, 1980 AND 1981 (N = 249)

Source of Treatment*	Family Advocacy Category		
	Child abuse	Spouse abuse	Sexual assault
Military	2	34	4
Civilian	60	62	2
Combination	29	54	2

* Initial emergency treatment was not included.

The high use of civilian sources of treatment may have been due to the lack of appropriate treatment and counseling services within the medical center. Also, the family or victim may have desired the privacy and anonymity of utilizing outside services. Although not a part of this research to decide, the compliance of victims and families with treatment plans may also have been related to the availability of resources for counseling.

The second of the remaining factors was that of involvement of drugs and/or alcohol in the incident. Table 16 presents the findings for this factor by case category. This factor was found to be documented in eighty-eight percent of the files reviewed.

TABLE 16

PRESENCE OF DRUGS/ALCOHOL IN INCIDENT BY CASE CATEGORY
NRMC CAMP PENDLETON FAMILY ADVOCACY FILES, 1980 AND 1981

Category	Percentage of Cases Involving Drugs/Alcohol
Child abuse/neglect (N = 145)	11
Spouse Abuse (N = 267)	46
Sexual assault/rape (N = 14)	7

Of all the cases in which it was documented, only a total of thirty-three percent involved drugs or alcohol. This seems quite low since alcohol, at least, has been shown to be a factor in up to eighty percent of cases of family violence.[13] Victims and families may not have admitted that alcohol or drug use was a factor in their problems because of shame, fears of abuser retaliation, fears of military prosecution of the abuser, or their own use of drugs or alcohol. However, these were only suppositions on the part of the researcher.

A profile emerged from the data analyzed from the FAP files. Families and individuals that were identified to the FAP were usually young, tended to be from the lower enlisted ranks, and were usually identified first in the Emergency Room of the hospital. This profile suggested that FAP efforts for prevention and treatment should be directed at this group as a target population.

PROCESS REVIEW

The review for process criteria included the same Family Advocacy Program files as did the outcome review. Files opened between January 1, 1980 and December 31, 1981 were examined for the presence of the five criteria developed from the BUMED instruction on the Family Advocacy Program. Process is defined as a sequence of acts or interventions in the delivery of care or service.[14] What was measured in

this component of the research was the degree to which the local program followed the processes outlined in the BUMED Family Advocacy Program. The criteria chosen were not meant to be all-inclusive. However, they were selected because they appeared to be indicated for all cases managed in the Family Advocacy Program (Appendix E contains the data retrieval form used for the process review).

Each file was scored against the five criteria with five being the highest score possible. Of the 482 files reviewed, 53 scored three or four. No files achieved a score of five. Of the remaining files, 13 scored zero; 288 scored one; and 128 scored two. Hypothesis testing at 0.05 level of significance failed to prove that files scoring three or greater represented a majority (p-value was less than 0.001). Thus, the research question was answered negatively in terms of the process measure.

The deficiencies found in the process review were fairly standard for each file reviewed. Table 17 shows the percentage of records deficient for each criterion on the process audit score sheet.

Of all the criteria, only the one requiring adequate identifying information was met by the majority of files. Criterion number 1 was found to be deficient for two reasons. First, there was a lack of documentation that the diagnosis was established by the committee. In fact, in many records, it appeared that the social worker had made the

TABLE 17

PERCENTAGE OF FAMILY ADVOCACY PROGRAM FILES DEFICIENT FOR EACH PROCESS AUDIT CRITERION (N = 482)

Criterion	Percentage of Files Deficient
1. Diagnosis established by FAP working committee.	84
2. Treatment Plan established by committee and documented in file.	90
3. Record review of files by FAR at designated intervals.	90
4. Adequate identifying information present.	3
5. Treatment recommendations made available to sponsor's command.	59

determination. Second, it was rarely noted in the record whether the incident of neglect or abuse was intentional or unintentional, yet this is a specific requirement of the BUMED instruction. Criterion number 2 was found to be deficient because, as already noted in the outcome measure, a treatment plan was not always documented in the files. It also appeared from the records that the treatment plan was not established by the committee but instead by the social worker on the case. Review of the record by the FAR was only rarely documented in the files as required in Criterion number 3. Criterion number 5 was not as significantly deficient

as the others noted. One reason for this was that this criterion applied only to the files of active duty beneficiaries.

The findings of this process review should not be construed to suggest that the local FAP is deficient because the BUMED procedural requirements were not followed. It may, in fact, have been more efficient and effective for the social worker to make preliminary determinations and to establish initial treatment plans given the delays in committee review already noted in the outcome measure. In some cases reviewed, it was discovered that the lack of committee involvement occurred because the case was managed by the Child Protective Service. However, the lack of committee involvement in these and other case determinations suggested that their functions were poorly defined. The BUMED requirement to notify the sponsor's command may not have been appropriate in all cases. The possibility existed that treatment compliance would have been compromised by such notification if the command was unsure of its role in the situation. These variations and lack of role definition highlighted the need for a written plan for the local FAP which would have fully outlined the procedures for the staff and the communities to follow as well as specified the role of outside agencies and military commands.

Another finding of both the process and outcome sections of the research was the lack of organization and content in the FAP files. While it was outside the scope of this

research to address the issue of proper FAP documentation, it was difficult to ignore the subject especially since much of the research involved these files. Some of the problems found in the content and organization of the FAP files were:

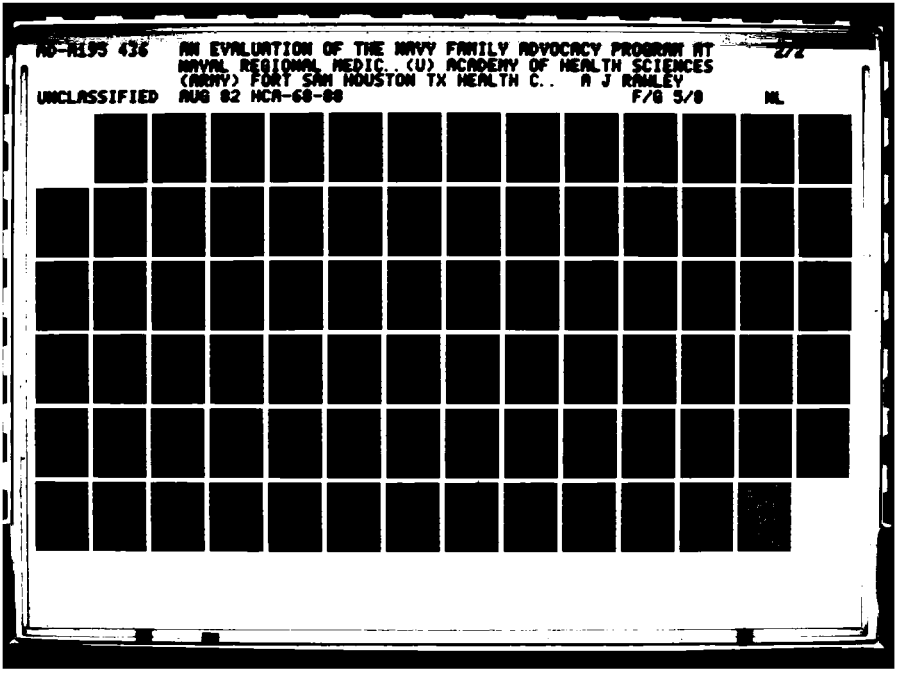
1. There appeared to be no specific arrangement for the documents and forms placed in the file.

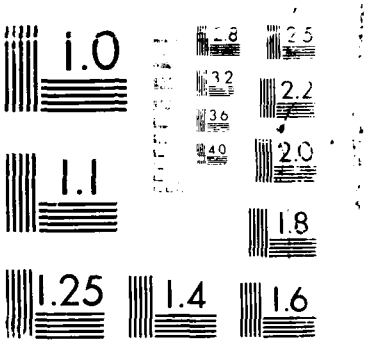
2. There appeared to be no specific requirements as to what types of forms were to be placed in the files.

3. Narrative notes were placed on plain, lined paper. Many of these notes were undated, unsigned, and illegible. The content of some of these notes was subjective and often did not appear to be directly related to the professional services rendered.

4. Uniformity of documentation was lacking. There appeared to be no specific policies on file content.

These discrepancies suggested, again, the need for specific local policies and procedures for the Social Work Service to follow in maintaining the FAP files. As noted in the BUMED instruction, some of these documentation procedures have to be determined by local legal and Navy-wide reporting requirements.[15] However, this does not obviate the need for NRMC procedures and formats applicable to the FAP files. The importance of adequate record-keeping cannot be over emphasized. Without this documentation, the review of care and services provided for quality and adequacy is impossible.


AD-A195 436
AN EVALUATION OF THE NAVY FAMILY ADVOCACY PROGRAM AT
NAVAL REGIONAL MEDIC.. (U) ACADEMY OF HEALTH SCIENCES
(ARMY) FORT SAM HOUSTON TX HEALTH C.. A J RAWLEY
UNCLASSIFIED
AUG 82 HCR-68-88
F/G 5/8
NL


1.0
1.1
1.25
1.4
1.6
1.8
2.0
2.2
2.5
2.8
3.2
3.6
4.0

Professional Awareness Measure of the Family Advocacy Program

In order to measure the Family Advocacy Program in terms of professional staff awareness, a six item questionnaire was sent to a random listing of military staff at NRMC Camp Pendleton (A copy of the questionnaire is provided in Appendix F). The sample size required for reliable estimation was determined to be 277. After a second request was sent to non-respondents, 232 questionnaires were returned. Since this amount represented an eighty-four percent response rate, it was decided that the remainder of the non-respondents could be ignored.[16]

Three of the six questions, numbers 3, 4, and 6, were used to measure the local program on professional awareness. Of the 232 respondents, sixty-one percent answered yes to two or more of these questions. Hypothesis testing at the 0.05 level of significance indicated that this represented a majority of the respondents (p-value was less than 0.001; test values are provided in Appendix I). Thus, on the measure of professional awareness, the research question was answered affirmatively. Table 18 shows the make-up of the sample occupational status. Males made up sixty-seven percent of the sample and females accounted for thirty-three percent.

The responses for each of the questions proved to be interesting. The majority of respondents, eighty-one percent, said that they knew how to recognize possible incidents of abuse, neglect and sexual assault. By occupational groups

TABLE 18

CLASSIFICATION BY OCCUPATION OF RESPONDENTS

TO PROFESSIONAL AWARENESS QUESTIONNAIRE
(N = 232)

Occupational Status	Number
Physician	38
Physician Assistant	2
Registered Nurse	38
Health Care Administrator	3
Allied Science Professional	12
Hospital Corps Staff	139

the results on this question were not widely disparate. However, on the question of knowing where and how to report the incident, only sixty percent of the total group responded positively. Table 19 presents the proportion of positive responses in each occupational group.

It was not surprising that all those in the Health Care Administrator group responded positively because many have had experience as the Duty Family Advocacy Representative. However, the fact that only about half of the Registered Nurse and the Hospital Corps groups responded positively appeared significant. These staff members are often in contact with patients and families and may become aware of

abuse or neglect. For this reason, they need to know where and how to report this information.

TABLE 19

PERCENTAGE, BY OCCUPATIONAL GROUP, THAT ACKNOWLEDGED KNOWING WHERE AND HOW TO REPORT INCIDENTS OF ABUSE, NEGLECT, AND SEXUAL ASSAULT

Occupational Status	Percentage of Positive Responses
Physician (N = 38)	76
Physician's Assistant (N = 2)	50
Registered Nurse (N = 38)	53
Health Care Administrator (N = 3)	100
Allied Science Professional (N = 12)	75
Hospital Corps Staff (N = 139)	56

Only twelve percent of the total respondents had received information or education about the Family Advocacy Program. This suggests a need for total staff education about the program. This questionnaire in no way tested the content and validity of the knowledge that the respondents said they had about recognition and reporting of abuse, neglect, and sexual assault. Since most of the respondents have never received information about the Family Advocacy Program, the accuracy of their knowledge, especially in terms of reporting, is questionable.

Staff attitudes regarding the military medical center's role in family advocacy were somewhat varied. Table 20 shows the percentage of responses for each objective listed on the questionnaire.

TABLE 20

OPINIONS OF SAMPLE NRMC CAMP PENDLETON MILITARY STAFF REGARDING THE ROLE OF THE HOSPITAL IN FAMILY ADVOCACY

Role	Percentage indicating medical center should have this role*
Reporting	88
Intervention	65
Treatment	79
Prevention	70
None of the above	2.5

*Percentages do not add to 100% because respondents could indicate as many roles as they chose.

While most respondents saw all four functions as the role of the medical center, the largest support was for the reporting and treatment functions. The lower percentage of respondents supporting intervention as a role may have been due to different definitions of this role among respondents. No attempt was made to define any of the roles or functions on the questionnaire which may have led to varying

interpretations of the words used. For example, intervention may have been seen as a punitive or police function rather than an initial crisis action to break a pattern or cycle of negative response to a stress.

Public Awareness Measure of the Family Advocacy Program

In order to measure public awareness of the Family Advocacy Program, a brief questionnaire was developed and distributed at entry points within the hospital, mainly the outpatient information desk. Based upon statistical determination, a sample size of 384 was required for reliability. After a two week period of survey distribution, 393 completed questionnaires were obtained (Appendix G contains a sample of the questionnaire used). Among the respondents, thirty-six percent were male and sixty-four percent were female. Ninety-one percent of the respondents were married; six percent were single; and three percent were widowed. Active duty Marine Corps personnel represented eighteen percent of respondents while other military active duty accounted for four percent. Of all the active duty respondents, eighty percent were enlisted rank and twenty percent were officers. Retired service members accounted for twenty-three percent of the sample. Dependent spouses were represented in fifty-three percent of the total number of completed questionnaires. Of these, seventy percent were spouses of active duty members and thirty percent were dependents of retirees.

Two percent of the sample fell into other beneficiary categories. No children were included in the survey. The high percentage of females, married persons, and dependent spouses in the sample was probably due to the fact that many of the active duty population receive much of their medical care at the branch clinics located throughout the base and thus do not frequent the hospital.

Two questions on the survey were utilized to assess the public awareness measure. One question asked if the respondent had received information regarding the Family Advocacy Program. The other questioned if the respondent knew that the hospital had services to help with problems such as child abuse and spouse abuse. Of the 393 respondents, forty-six percent answered affirmatively to at least one of these two questions. Hypothesis testing at the 0.05 level of significance showed that this proportion did not represent greater than fifty percent of the sample (p-value equals 0.056; test values are provided in Appendix I). Thus, the assessment of public awareness did not answer the research question positively. Table 21 provides a breakdown of the response percentages for each of the three questions in the survey.

The results of the survey suggest that although a fair proportion of the respondents were aware of hospital services for child abuse and spouse abuse, they had received no specific information on the Family Advocacy Program. A

TABLE 21

PERCENTAGE OF POSITIVE RESPONSES TO THE PUBLIC AWARENESS SURVEY QUESTIONS ON THE FAMILY ADVOCACY PROGRAM

Question	Percentage of positive responses*
1. Have you received information regarding the Family Advocacy Program?	9
2. Were you aware that this hospital has services to help with problems of child abuse/neglect and spouse abuse/ neglect?	41
3. If you or your family were having problems such as child abuse or spouse abuse, would you seek help at this hospital?	81

*Percentages do not equal 100% because respondents could answer yes to more than one question.

publicity campaign would help to provide the beneficiary population with this information. This seems especially important since the survey suggests that many would seek help at the hospital for family problems. However, self-referral would be enhanced by adequate public knowledge on the appropriate hospital department to contact for assistance.

Interviews with Family Advocacy Committee Members

Semi-structured interviews, utilizing the tool provided in Appendix H, were conducted with members of the main Family Advocacy Committee and the five working or

sub-committee members. These sub-committees included the ones for child abuse, spouse abuse, and sexual assault as well as the ones for high risk families and for education. While most of the questions dealt with program effectiveness, the interview was conducted so that committee members could expound upon their answers or add comments as they chose. Thirty-nine of the forty-five members were available and willing to be interviewed.

The main thrust of the interview was to obtain trends and ideas about the Family Advocacy Program. Respondents were assured that their names and positions would not be mentioned in the research. This was done to guarantee privacy and, hopefully, to elicit honest answers and comments.

Of the thirty-nine committee members interviewed, twenty-three were hospital staff members; ten were from various military agencies on the base; and six were from civilian organizations and agencies. Of the six members not interviewed, five were hospital staff and one was from a military agency. The committees were obviously well represented in terms of hospital staff. Of the total twenty-eight hospital staff members, twelve were physicians; six were nurses; and the remainder were social workers, psychologists, dental officers, chaplains, and administrators. The military agencies having membership included the military police (Provost Marshal's Office), base legal, Human Affairs Officers for each major military command, Naval Investigative Service,

Navy Relief Office, and Family Services Center. The civilian agencies represented included the local police department, the public health nursing service, the Armed Forces YMCA, and two private agencies that provide protective and assistance services to women and children.

The interview consisted of four questions. Three of these were specific and one was general asking only for comments and suggestions regarding the Family Advocacy Program. The first question asked for opinions about what the objectives of the hospital's FAP should be. The majority of responses fell within the following areas:

1. Identification and diagnosis of cases of family dysfunction.

2. Prevention of family problems through general education programs and assistance to individual families.

3. Intervention at time of family/individual crisis.

4. Referral to and coordination with appropriate agencies for treatment.

In addition to these areas, which most respondents mentioned, nine members suggested that the hospital should be able to provide long-term treatment for families and individuals identified through the program.

The second question asked for members' opinions about the current effectiveness of the Family Advocacy Program. The majority of those interviewed indicated that in identification of cases and initial intervention, the program was

most effective. About a third of the members felt that the program was also successful in referral and follow-up management after crisis intervention. Surprisingly, five of the respondents did not believe they had enough information to make a judgment on program effectiveness.

On the question asking for an opinion of the BUMED instruction on the Family Advocacy Program, the responses were less positive. Seventeen members were not familiar with the instruction. Of those unfamiliar with it, six were hospital staff and eleven were representatives of other military and civilian agencies. None of the five civilian representatives had ever seen or read the BUMED instruction. Only seven of the members thought the instruction was adequate in providing guidelines, but some of these believed it was adequate only because it filled a pre-existing void or at least provided a structure for family advocacy efforts.

Sixteen of the members interviewed believed that the instruction was inadequate for a number of different reasons. The inadequacies perceived in the BUMED instruction were that it:

1. Provided no resources for implementation.
2. Provided no specific procedures to follow.
3. Provided no measureable goals and standards for local programs to utilize.
4. Had no specific objectives for the data collected.
5. Was an overreaction to social pressure and, thus, was formulated without adequate guidelines.

These comments regarding the BUMED instruction were echoed again in response to the last question which simply asked for comments and suggestions regarding the Family Advocacy Program. While three of the respondents believed the local program was working well, the majority expressed criticisms about the program structure and the procedures especially with regard to the committees. The committee format and meetings received numerous comments. The meetings were criticized for not accomplishing anything because no goals, purposes, or procedures were defined. In addition, many members felt that the committees could not accomplish anything because the numbers of participants were too large and the meetings lasted too long for any real decision-making.

Not only were the committees' roles considered ill-defined, but also the roles of the various outside agencies, both military and civilian were unclear to many of the participants. While the members from those agencies outside the hospital expressed this sentiment most frequently, at least four of the hospital staff members also mentioned it. Poor role definition was frequently indicated with regard to investigative and jurisdictional issues. This concern was expressed both by military and civilian participants who suggested that there seemed to be too much duplication of effort with many agencies conducting investigations and no agency coordinating these activities. Some committee members expressed frustration with the lack of role definition,

although they suggested that the lack of identified roles resulted from the program being simply too large for the hospital alone to coordinate. Even the reporting of suspected cases caused confusion. Some hospitals thought the FAP should handle only cases identified within the hospital. Some committee members from the outside agencies seemed to think that cases identified outside the hospital should be reported to the FAP.

Other concerns expressed by committee members also seemed significant. There was a considerable amount of criticism of the requirements to attach stigmatizing labels to individuals and families with no apparent benefit. This was noted particularly with regard to the record reveiw required for individuals and families designated as "high risk". According to committee members who mentioned this program requirement, the outpatient medical records of these so-called "high risk" individuals and families were marked with special labels. FAR review of these health records was required every time the individual sought medical treatment. The criteria used in designating these "high risk" clients and the purpose of FAR monitoring of their records was unclear to some of the committee members interviewed. The practice was criticized on the grounds that it turned the FAP into a quasi-police or "watchdog" agency by branding individuals and families as criminals and victims before any incident had occurred. The way in which this practice benefited the

families involved was also unclear to the committee members who mentioned it in the interviews.

Another concern expressed by some interviewees, was the use of committee meetings as the vehicle for agency referral and exchanging of information about individuals and families. A number of committee members remarked that this procedure resulted in overly-long meetings because of the need for the FAR to present detailed case histories to inform the other agencies that might have an interest. Because the other agencies were not always notified prior to the meetings of the cases to be discussed, they were often unprepared to provide needed information. In fact, the practice of presenting case histories in front of these committees was criticized as being an unnecessary invasion of privacy and confidentiality because it exposed information of a highly personal nature to individuals who did not always have an interest in or a need to know it.

The problem of resource availability was also noted by some of those interviewed. Cutbacks in federal and state funding for the civilian agencies, such as the Child Protective Service and the Department of Public Health Nursing Service, that currently serve the military as well as the civilian population, were mentioned as possible future limitations in providing response and outreach assistance to dysfunctional families. There was concern expressed that the military would do nothing to make up for the void in civilian agency

services created by decreases in funding.

The efforts of the hospital Social Work Service were praised by at least six of the hospital staff members interviewed, but many felt that the department was understaffed and not powerful enough to manage the FAP. The small size of the Social Work Service was also blamed by a few of the interviewees for the lack of programs to provide long term counseling for dysfunctional families.

Suggestions on ways to improve the Family Advocacy Program were not as numerous as the criticisms. Five committee members indicated that increasing the Social Work Service staff would be a solution. However, eight of the respondents suggested that the program could be improved by decreasing the number of functions that the hospital now assumes in family advocacy. By assigning the investigative, reporting, coordinating, and prevention responsibilities to outside military agencies, the hospital could concentrate its efforts and resources on developing services for evaluation, treatment, and support of families and individuals in need. The hospital, according to some interviewees, should not be making the determinations about whether or not abuse or neglect occurred. Instead, the hospital staff's role should be limited to identifying that trauma or neglect did not appear to be accidental or unintentional and reporting these incidents to an outside military agency. A designated base agency would investigate and determine if, in fact, abuse or neglect had

occurred. Then individuals and famlies would be referred back to the hospital for treatment and counseling as needed.

It was also suggested that the hospital needed to provide outreach services such as clinics in outlying housing areas and public health nurses to do home visits for the purpose of needs assessment, emotional support, and health teaching for troubled famlies. These suggestions were voiced in relation to the projected cutbacks in services from civilian agencies.

Throughout the interviews, there was indication that some dissatisfaction existed among many who participated in the Family Advocacy Program. While not severely critical of the program itself, some of the representatives from the military agencies, some civilian agencies, and even hospital staff expressed confusion and frustration in working with the program as it currently operates. Some of those who did not express any frustration also admitted that they rarely attended the meetings. Others suggested that communication between the hospital and the outside agencies needed improvement. It was suggested by these individuals that much of the information sharing regarding the FAP cases should occur outside and prior to the meetings. Such a communication would protect the individual's privacy and decrease the time spent in the meetings. A few interviewees demonstrated a total dislike for the whole method of handling family problems in a committee especially when the committee's decisions could be

detrimental to a service member's career and ultimately prove to be of no benefit to him or his family. On the other hand, there were those who praised the committee meetings as excellent opportunities to encourage and enhance communication among the various agencies.

No attempt was made to accord any statistical significance to the results of the interviews. However, it must be noted that while most participants supported the concept of family advocacy, they did not all agree that the hospital should act as the controlling agency for a Family Advocacy Program. Others may not have been as candid as possible because of the researcher's position as a member of the hospital staff. The fact that some committee members saw no problems with the program could have been related to a sense of loyalty to those who had devoted significant amounts of time and effort to the hospital's Family Advocacy Program. Of course, these are only researcher speculations drawn from impressions regarding the interviews rather than any specific remarks or content. However, the one theme that seemed to be common to a majority of the responses about the FAP was that other military agencies should have a larger role in what is currently a hospital-dominated program.

Cost of the Family Advocacy Program

In attempting to capture the cost of the Family Advocacy Program, the first step was to examine the costs of

the Social Work Service because this department was involved in the daily management of cases. The FAP is not directly funded so all costs must come from available resources. The total annual budget for fiscal year 1981 for this department, including the salary of the one military social worker and the two civilian social workers, was $78,105.80.[17] Using the 15 minutes as the direct service time units, a total of 15,588 time units available annually was calculated for the three social workers in the department (The detailed calculations for this figure and all others in this section are provided in Appendix K). The cost for each direct service time unit was estimated at $5.01. Based on a total of 3,465 Social Work Service visits in fiscal year 1981, the average number of time units per visit was 4.5 or approximately 68 minutes per visit.[18] The average cost per visit was $22.55. Based only on caseload figures, Family Advocacy Program visits were estimated to be seventy-one percent of the total visits. From this figure, the estimate of the proportion of the total Social Work Service Costs devoted to the Family Advocacy Program equalled $55,455.12.

Since no comparison costs were available from other Family Advocacy Programs, there was no way of determining whether these costs were high or low. However, since the outcome research showed that treatment plan establishment and compliance occurred in twenty-three percent of the FAP cases, only about $13,000 of the total costs estimated for Social

Work Service involvement in the FAP could be related to successful outcomes. This suggested that the program might not be cost-effective. However, the lack of documentation may have been a factor. Also, there appeared to be so many program objectives that trying to relate costs to achievement of these objectives may be irrelevant.

Another factor which was not studied, but would have been significant in a true cost-benefit or a cost-effectiveness analysis, was the prevention of further incidents of abuse and neglect after program intervention. Such prevention would certainly be considered a benefit because the total costs for the medical center to examine, hospitalize, and treat such victims prior to any social service intervention are likely to be high. Another cost, not accruing to the medical center but certainly a DOD expense, would be the CHAMPUS cost of providing counseling and treatment for dysfunctional families at civilian sources. An extensive comparative cost analysis of providing these services within the medical center and sending beneficiaries out to civilian sources would be worthwhile before any decision is made to develop local treatment programs.

The average of sixty-eight minutes for each Social Work Service visit appeared rather long, particularly since the staff there indicated that they provide only intervention and referral without any long-term treatment or counseling. Because no time studies were done to determine real time per

visit, it was only possible to surmise that visits were actually not this long. It is possible that much staff time was instead involved with activities such as making referrals and preparing for the many committee meetings of the FAP. The number of committee meetings per year were calculated to be eighty-eight per year, including four for the Family Advocacy Committee, twenty-four each for the Spouse Abuse Subcommittee and the Child Abuse Subcommittee, and twelve each for the Sexual Assault Subcommittee, the High Risk Subcommittee, and the Education Subcommittee. Because so many of the committee members interviewed indicated that they saw little benefit accomplished by these meetings, an estimate of the hours used by hospital primary and direct providers in the meetings was estimated. Based upon a conservative estimate of a one-hour length for each of these meetings and a supposition that each direct-service provider attended every meeting, a total of 632 direct provider hours annually was calculated for all FAP meetings (the estimate of only one hour per meeting was used, even though meetings often last much longer, to correct for the clinicians who did not attend). Even if only one patient could be seen for each hour, a minimum of 632 patient visits per year were lost to time spent in FAP meetings. This loss would be insignificant if the meetings proved beneficial, but the results of the process review and the interview data suggested that this was not the case.

It must be noted that the data presented in this cost

analysis was in no way meant to be all-inclusive. A true cost-benefit analysis would have included all the costs of the FAP both within and outside the medical center. It would have related these costs to all the possible benefits such as decreased expenditures for medical care, gain in military productivity as a result of improvement in family and individual functioning, and decrease in pain and suffering for individuals and families. In terms of cost-effectiveness, the hospital's social work program could have been compared to other programs in terms of costs and results. Also, a cost-effectiveness analysis could be used to determine whether or not the work of the hospital-based FAP effects a cost savings for other military and civilian social service agencies. As far as cost-efficiency it would be worthwhile to examine the possibility of reducing program costs by determining specific targets for intervention and by shortening the length of interviews. The framework for this research did not allow for such extensive cost analysis. Consequently, they are offered here as questions to be addressed prior to any local proposals to expand or contract the current FAP and the Social Work Service.

Chapter II Notes

[1]U.S., Department of the Navy, Bureau of Medicine and Surgery, Family Advocacy Program, Instruction No. 6320.57, 11 July 1979, Enclosure 1, p. 5.

[2]Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals, 1982 Edition (Chicago: Joint Commission on Accreditation of Hospitals, 1981), p. 179.

[3]Saad Z. Nagi, "Child Abuse and Neglect Programs: A National Overview", Child Today 4 (May-June 1975):14.

[4]Britt Finley, "Nursing Process with the Battered Woman", Nurse Practitioner 6 (July-August 1981):11.

[5]D. Jean Schneider, Donald Blydenburgh, and Gail Craft, "Some Factors for Analysis in Sexual Assault", Social Science Medicine 15A (January 1981):55.

[6]Arthur Kaufman et al, "Male Rape Victims: Noninstitutionalized Assault", American Journal of Psychiatry 137 (February 1980):221.

[7]Sandra Maley Schnall, "Characteristics and Management of Child Abuse and Neglect Among Military Families", in Children of Military Families--A Part and Yet Apart, ed. Edna J. Hunter and D. Stephen Nice (Washington, D.C.: U.S. Government Printing Office, 1978), p. 145; Terrance D. Wardinsky and William Kirby, "A Review of Child Maltreatment at a USAF Medical Center", Military Medicine 146 (May 1981):328.

[8]Sandra Maley Schnall, "Characteristics and Management of Child Abuses and Neglect Among Military Families", in Children of Military Families--A Part and Yet Apart, ed. Edna J. Hunter and D. Stephen Nice (Washington, D.C.: U.S. Government Printing Office, 1978), p. 145.

[9]Ibid., p. 109.

[10]Kaufman, p. 223.

[11]Elaine Hilberman, "Overview: 'The Wife-Beater's Wife' Reconsidered", American Journal of Psychiatry 137 (November 1980):1342; Arthur Kaufman et al, "Male Rape Victims: Noninstitutionalized Assault", American Journal of Psychiatry 137 (February 1980):221; Gerald Solomons, "Trauma and Child Abuse", American Journal of Diseases in Children 134 (May 1980):503.

[12]Elaine Hilberman, "Overview: 'The Wife-Beater's Wife' Reconsidered", American Journal of Psychiatry 137 (November 1980):1339.

[13]Evan Stark, Anne Flitcraft and William Frazier, "Medicine and Patriarchal Violence: The Social Construction of a 'Private' Event", International Journal of Health Services 9 (March 1979):467.

[14]Jerry Flanzer, "The Vicious Circle of Alcoholism and Family Violence", Military Family 1 (Fall 1981):3.

[15]U.S., Department of the Navy, p. 53.

[16]Stephen Isaac, Handbook in Research and Evaluation (San Diego: EDITS Publishers, 1980), p. 93.

[17]Budget figures were provided by the Comptroller Service, NRMC Camp Pendleton.

[18]Numbers of visits were taken from statistical listings published for NRMC Camp Pendleton.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The Research Question

The research was conducted to provide a comprehensive study that would evaluate the Navy's Advocacy Program by an in-depth examination of the program's organization, implementation, and results at NRMC Camp Pendleton, California. The research methodology was composed of seven parts which investigated the local FAP in terms of structure, outcome, process, professional awareness, public awareness, costs, and committee members' opinions. The first five parts of the research were designed to determine whether or not the local FAP met the requirements of the BUMED instruction. The remaining two parts were included to collect additional information that would provide a comprehensive picture of the local FAP and generate some suggestions for improvement.

In the structure component of the research, it was found that the local FAP met the BUMED requirements on only twelve of the forty-six items investigated. This was not a majority. The outcome measure, which consisted of a review

of 482 case files, showed that while the local FAP matched general population reporting rates for child abuse and sexual assault, it was not so successful with spouse abuse cases. The other outcome measure, that of treatment plan compliance by victims and families identified to the program, was not successfully met by the local FAP in the majority of files reviewed. Procedures, that are required by the BUMED FAP instruction, were not followed in the local FAP as discovered in the process review. Out of the 482 files matched against five process criteria, only 53 scored three or better. In terms of professional awareness, the survey of 232 hospital staff members showed that sixty-one percent were informed about the FAP. Since this was proven to be a majority of those surveyed, the local program was judged to have met BUMED requirements in this research component. However, in terms of public awareness, only forty-six percent of the 393 beneficiaries surveyed indicated cognizance of the FAP. This was not shown to be a majority. Thus, the local FAP was judged to have failed to meet BUMED requirements for public education about the program.

Because the local FAP failed to meet four out of five of the research measures, it was determined that the answer to the primary research question was negative. The Family Advocacy Program, as required by BUMED Instruction 6320.57, was not realistic and manageable at the local command level, and was not effective in accomplishing its

objectives of intervention, treatment, and prevention. However, it must be noted that if identification and intervention are equated, the local program did partially meet the intervention objective by adequately identifying child abuse and sexual assault/rape cases. It, however, was not as successful in identifying spouse abuse cases. As far as the objective of prevention, the answer to the question was not clear. The public awareness measure was assumed to determine the success of education aimed at primary prevention. However, the success of a secondary prevention program, such as the "high risk" program, was not measured by this research. In terms of treatment, there was no question, as far as the results of the research, that the local program did not meet this objective.

The negative answer to the research question was surprising because the NRMC Camp Pendleton FAP has been viewed by BUMED authorities as one of the best of the Navy's Family Advocacy Programs. The inability of NRMC Camp Pendleton to meet at least some of the BUMED FAP requirements was also surprising because this facility has devoted more resources than other naval medical commands, especially in terms of the size of the Social Work Service staff, to the FAP effort.

The reasons for the lack of local compliance with the BUMED FAP requirements were not made perfectly clear by the results of the research. However, the findings of all

the research components seemed to suggest that the BUMED requirements were simply too many and too great for one agency to implement and manage. Thus, simply continuing to increase the size of the Social Work Service staff was not supported as an answer to the deficiency of local command compliance with these requirements. The multiple committee structure, with its large membership and lengthy meeting times, appeared to be unwieldy, inefficient, and ineffective. Committee members' roles were unclear, with most of the actual case preparation, determinations, and management being handled by the Social Work Service. Because the BUMED FAP instruction applied only to medical and dental commands, the cooperation of other military agencies and commands could only be requested and not demanded. The lack of specific funding for the FAP precluded devotion of resources to this effort alone. Instead, the local medical command staff had to assume this program using resources already availalbe. Consequently, the multiple objectives of the FAP, including identification, evaluation, intervention, treatment, and prevention of abuse, neglect, sexual assault, and rape could not receive the amount of resource application necessary for program success. In fact, according to the research findings and committee members' opinions, the program was only successful in terms of one objective, identification.

Related Research Findings

In addition to the research findings related to the primary research question, other discoveries were made in conducting the data collection and analysis. One major finding was that both the FAP and the Social Work Service lacked well-developed internal organization and procedural documents to define roles and guide functions. Hospital instructions referred mostly to initial intervention and reporting procedures for physicians and the DFAR. Another discovery was that FAP file content was poorly documented, illegible, and disorganized. There appeared to be specific requirements for these records.

Although the majority of hospital staff surveyed indicated knowledge about the identification and reporting of abuse and neglect incidents, the accuracy of their learning was questionable because the majority also indicated that they had never received written material or specific education about the FAP. This survey also indicated that the majority of staff believe that the hospital should assume all the major functions of the FAP despite limited resources. However, the results of the interviews with FAP committee members suggested the need for increased involvement by other military agencies and a less dominant role for the medical center.

Recommendations

The Navy's Family Advocacy Program

Although an instruction from the Secretary of the Navy (required as a result of DOD Directive 6400.1) has not yet been issued, it is expected that involvement of all Navy and Marine Corps commands in the Family Advocacy Program will be a requirement of this forthcoming instruction. Because of the results of this research and, also, the findings noted in the review of the literature, it is recommended that program control and coordination at the local level not be delegated to the medical command. Family dysfunction resulting in child abuse/neglect and/or spouse abuse is a multifaceted problem with legal, social, cultural, occupational, and medical components and consequences. As Nichols has pointed out, there is a need for organizational structures that will provide clear authority and workable procedures for dealing with family concerns and for integrating family issues into the broader concerns of military operations and military management.[1] The military medical center alone cannot provide such an integrating structure because it has neither the resources nor the authority to address all the components of family dysfunction. Only the larger military community, via the line commands and with the assistance, advice, and support of the medical commands, can

generate the multidisciplinary/interdisciplinary integration, coordination, and cooperation to address multifaceted family problems which are affected by and, in turn, can affect military operations and management. When program responsibility and control resides in the community-at-large, whether military or civilian, there is less chance for the development of "turfism" and "tunnel-vision" that often leads health and social work professionals to dictate the appropriate methods for dealing with such problems as child abuse.[2] Such dictating to the community is likely only to result in program failure and community resentment of the so-called "experts".

The multiple tasks and objectives of a Family Advocacy Program have been shown by this research to be simply too great for the hospital to manage. However, the military hospital, like its counterparts in the civilian community, can be delegated, by the line commands, an appropriate role in the identification, evaluation, and treatment of dysfunctional families that come to its attention. As already mentioned, the military medical community can act as consultants to the line commands, providing recommendations for individual case management and suggestions for public education. However, the legal issues, such as civilian jurisdiction on a military reservation and agreements with the family/juvenile courts and civilian family welfare agencies for case reporting and management, are most appropriately addressed at the

highest levels of the base command in order to insure compliance, cooperation, and understanding on both sides.[3] Finally, only a Family Advocacy Program, based on the larger military community, can develop the public awareness and concern necessary for program success.[4]

The Local Family Advocacy Program

Recommendations regarding written organization, policy, and procedure documents, both for the FAP and especially the hospital's Social Work Service, have already been discussed at some length. In addition, it is recommended that Social Work Service upgrade and organize its recording prodecures. Some areas to consider in designing an appropriate record format are:

1. A client/family assessment at time entry.
2. Social treatment plans and actions.
3. Community/military agency involvement.
4. Outcome or results.[5]

It is also recommended that record quality reviews, on a sample basis, be conducted at regular intervals.

Because the current committee structure proved to be so unwieldy, it is also recommended, depending upon the hospital's future role in the Family Advocacy Program, that the hospital consider the small-size team approach to evaluation and management of child abuse, spouse abuse, and sexual

assault/rape cases. Such a team approach is well-documented in the literature. By limiting team size to about four professionals from various disciplines, having multiple teams available to prevent overburdening a few staff members, and developing a specific protocol for managing hospital-referred cases, evaluation and treatment plans could be formulated rapidly, perhaps withing 2 to 3 days of an incident, and forwarded for approval to the appropriate civilian and/or military agency.[6] It is most important that this process be achieved swiftly so that famlies and individuals receive the assistance they need before another incident occurs.

Other programs for the hospital to consider are those which are often already in place, but may not be effectively integrated into a total approach to family advocacy. Such programs, as enhancement of parent-infant attachment (bonding) and "at risk" screening of families, have received much recognition in the literature.[7] With screening programs such as these, it is important that the criteria are well-developed and well-publicized among the various health care professionals so that, for example, the pregnant adolescent receives counseling and referral prior to delivery of her child.

Programs in the community which encourage improved family functioning should also be provided. Prenatal education classes should not be limited to just preparation for

the birth experience but, instead, should expand to address the whole concept of being a parent by emphasizing child development and behavior.[8] The military community could sponsor Parents Anonymous groups in the same way that support has been provided Alcoholics Anonymous groups. Perhaps similar support groups can be developed for spouses who are abusers. No matter what kinds of programs are developed, it is most important that publicity for such programs receive enough emphasis to generate community interest and participation.

Recommendations for Future Research

This research project could not possibly address all the issues that arise about the Family Advocacy Program. In fact, it has possibly raised more questions than it has answered. Some of these have been mentioned along with the research findings. The importance of cost-effectiveness and cost-efficiency analysis cannot be overemphasized because of continual resource limitations. However, such investigation is impossible unless program objectives are defined and program evaluation techniques are incorporated from the start.

Other areas recommended for future research in the military community are:

1. Review of medical records to determine whether or not adequate identification of abuse, neglect, and sexual assault is achieved.

2. Development of coordination between programs for drug abuse, alcohol abuse, and family advocacy.

3. Feasibility of developing funded outreach programs in Navy and Marine Corps communities to include home visits by community health nurses and at home assistance to dysfunctional families by parent aides.

4. Instilling and publicizing a military philosophy during recruit training and indoctrination which supports family advocacy and condemns child abuse/neglect, spouse abuse and sexual assault/rape.

While further research is always needed, what is most important is the continuing necessity for those who must determine and implement military policy decisions to be aware of the enormous impact those decisions have upon the functioning not only of the individual service member but also his/her family.

Chapter III Notes

[1]Robert S. Nichols, "The Military Family/Military Organization Interface: A Discussion", in The Military Family and The Military Organization, ed. Edna J. Hunter and Thomas C. Shaylor (San Diego: United States International University, 1979), p. 66.

[2]Thomas R. Sefcik and Nancy J. Ormsby, "Establishing a Rural Child Abuse/Neglect Program", Child Welfare 57 (March 1978):188,190.

[3]U.S., Department of Health and Human Services, National Center on Child Abuse and Neglect, Child Protection in Military Communities, by Dianne D. Broadhurst et al, DHHS Publication No. (OHDS) 80-30260 (Washington, D.C.: Kirshner Associates, 1980), p. 50-2.

[4]Sefcik, p. 191.

[5]American Hospital Association, Professional Standards Review for Hospital Social Work (Chicago: American Hospital Association, 1977), p. 30.

[6]Sefcik, p. 191.

[7]David L. Kerns, Jane Cavanaugh, and Benjamin C. Berliner, "Child Abuse and Neglect: The Hospital's Expanding Role in Prevention, Identification and Management", Connecticut Medicine 43 (May 1979):297-8.

[8]Ibid., p. 298.

APPENDIX A

DEFINITIONS OF TERMS AND ACRONYMS USED

The following definitions and abbreviations have been used throughout the research project.

ABUSE: Direct physical injury, trauma and/or emotional harm inflicted other than by accident.

BUMED: Bureau of Medicine and Surgery, U.S. Navy.

CHILD: An unmarried person, whether natural child, adopted child, foster child, stepchild, or ward, who either: (1) Has not passed his/her eighteenth birthday; (2) Has not ecome legally emancipated; (3) Is incapable of self-support because of a mental or physical incapacity that currently exists and for whom treatment is authorized in a medical facility of the uniformed services.

CHILD ABUSE/NEGLECT: Abuse/neglect in which the abuser or neglector is responsible for the child's welfare. This includes parents, guardians, or other individuals or agencies charged with the welfare of the child.

DFAR: Duty Family Advocacy Representative, an individual designated by the commanding officer to augment or represent the Family Advocacy Representative in his or her absence.

FAC: Family Advocacy Committee, a committee, the purpose of which is to oversee the functioning of the Family Advocacy Program at the local level.

FAP: Family Advocacy Program, a program which includes identification, evaluation, intervention, treatment, and prevention of abuse, neglect, sexual assault, and rape.

FAR: Family Advocacy Representative, a person designated by each commanding officer to implement and manage the Family Advocacy Program at the local level.

GAO: General Accounting Office of the U.S. Congress.

HARM: Includes, but not limited to: (1) Physical, emotional, or mental injury, including physical injury resulting from otherwise lawful corporal punishment which may become unlawful when it dis- figures, impairs, or otherwise traumatizes an individual; (2) Sexual offenses, whether assaultive or nonassaultive, accomplished or attempted; (3) Failure to supply a child with adequate food, clothing, shelter, education, or health care, though financially able to do so or offered financial or other reasonable means to do so; (4) Abandonment of a child or spouse, as defined by applicable statutes; (5) Failure to provide a child with adequate care, supervision, or guardianship.

HIGH RISK/AT RISK: Vulnerable; a family, individual, or situation in which an event or occurrence is likely though not present.

MALTREATMENT: A general diagnostic term referring to abuse and/or neglect.

MALTREATMENT, ESTABLISHED: Essentially, a diagnostic term indicating a Family Advocacy Committee or its working subcommittee had collected sufficient information and made a collective judgment that maltreatment has indeed occurred. In addition to the patient's physical condition and information received from family members or collateral contacts, a diagnosis of established maltreatment may be based upon results of investigations conducted by the Naval Investigative Service; military, State, county, or local child welfare or protective agencies; State, county, or local law enforcement agencies; military law enforcement groups; or those conducted in accordance with the JAG manual.

MALTREATMENT, SUSPECTED: Essentially a diagnostic term indicating: (1) Sufficient evidence exists to warrant a report to appropriate authorities in accordance with applicable statutes; (2) A Family Advocacy Committee has reviewed reported evidence and made a collective judgment that maltreatment may have occurred, but insufficient evidence to warrant a diagnosis of established maltreatment.

NEGLECT: Acts of omission or commission comprising inadequate and/or improper care which result or could reasonably result in injury, trauma, or emotional harm. This includes, but is not limited to, abandonment, exploiting individuals, or failure to attend to welfare.

NEGLECTOR OR ABUSER: The person or persons directly or indirectly responsible for the resultant neglect or abuse which occurs to an individual.

NRMC: Naval Regional Medical Center.

RAPE: Sexual intercourse by a man with a woman who is below the statutory age of consent, or nonconsensual intercourse by a man with a woman who is not his wife. Carnal knowledge of a female through the use of force or threat of force.

SEXUAL ASSAULT: A nonconsensual act of noncoital sexual contact. The term also includes "homosexual 'rape'" and nonconsensual coitus by a man with his wife, unless those concepts are defined as rape by provisions of State law.

SPOUSE: A partner in a lawful marriage.

SPOUSE ABUSE: Non-accidental physical or psychological injury inflicted on either husband or wife by his/ her marital partner.

UNFOUNDED REPORT: A report made pursuant to State law for which FAC investigations reveal there is no probable cause to believe that the individual was abused, neglected, or sexually assaulted.

VICTIM OF ABUSE OR NEGLECT: Designates an individual whose physical or mental health or welfare is harmed or threatened with harm by acts or omissions of another individual or individuals.

APPENDIX B

MISSIONS AND TASKS

NAVAL REGIONAL MEDICAL CENTER, CAMP PENDLETON

Mission

To provide general clinical and hospitalization services primarily for active duty Navy and Marine Corps personnel and active duty members of other Federal Uniformed Services and to provide general clinical and hospitalization services for other authorized persons as prescribed by Title 10, U.S. Code and other current directives to the extent that such effort does not interfere with the provision of care to active duty members. Provide clinical specialty and sub-specialty services as directed. Provide coordinated clinic health care services for all medical treatment facilities and activities assigned and exercise local coordination of other functions as directed. Participate as an integral element of the Naval and Tri-Service Regional Health Care systems. Cooperate with military and civil authorities in matters pertaining to public health, local disasters, and other emergencies.

Functions

a. Command and operate the Camp Pendleton Naval Regional Health Care System.

b. Provide branch clinic, general clinical, and hospitalization services for authorized personnel.

c. Serve as responsible central agency for the resolution of complaints, deficiencies, and problems to improve health care to all beneficiaries.

d. Conduct an educational and public relations program to enhance patient, staff, and command satisfaction.

e. Conduct a personnel management program for selective rotation of Medical Department personnel between regional medical facilities for educational training and experience purposes to achieve more efficient and effective use of health care resources.

f. Provide and coordinate professional clinical services for the assigned medical treatment facilities.

g. Conduct specialty clinics at one or more of the branch clinics as required.

h. Provide and coordinate administrative and logistics services for the assigned medical treatment facilities.

i. Maintain liaison with the line commands upon which the medical treatment facilities are located.

j. Perform the functions of a regional hospital for those activities outlined in current DOD directives.

k. Perform automatic data processing services and serve as a Naval Regional Data Center for assigned medical facilities.

l. Operate a whole blood donor center.

m. Train, maintain and prove augmentation personnel for immediate availability to the operating forces as directed by higher authority.

n. Provide personnel for, train, and maintain surgical teams, surgical support teams, and other special teams as outlined in current directives to be immediately available to the operating forces when directed by the Chief of Naval Operations.

o. Maintain a command blood program which maximizes utilization of blood products by interchange of blood and components between command elements.

p. Conduct formal training of Group X hospital corpsmen in the technical specialties outlined in current BUMED directives.

q. Provide on-the-job training in specialties for Group X hospital corpsmen and Group XI dental technicians as appropriate.

r. Conduct inservice training for Group X hospital corpsmen and Group XI dental technicians.

s. Perform formal physical examinations of candidates for admission to the armed services academies and other special examinations as required.

t. Negotiate intraservice support agreements as necessary.

u. Assign specific tasks to each organizational element as necessary to accomplish the mission.

v. Prepare and maintain, in accordance with current directives, an up-to-date disaster preparedness plan including procedures for mass casualty processing.

w. Conduct Decedent Affairs Program under the general supervision of BUMED and in coordination with the program administered by the district commandants as outlined in current directives.

x. Maintain standards for accreditation as recommended by the Joint Commission on Accreditation of Hospitals.

y. Conduct residency training for U.S. Naval Medical Officers and General Dental Residency training for Dental Officers and observerships for foreign medical personnel.

z. Conduct Residency Training Program in Family Practice.

aa. Perform Regional Sanitation and Preventive Medicine functions.

bb. Conduct an Industrial Health program on a regional basis.

cc. Provide or undertake such other appropriate functions as may be authorized or directed by higher authority.

APPENDIX C

STRUCTURAL ITEM TOOL

STRUCTURAL ITEM TOOL--FAMILY ADVOCACY PROGRAM

ITEM DESCRIPTION	PRES.	ABS.	DOCUMENT WHERE ITEM FOUND	COMMENTS
1. A social worker is designated as the Family Advocacy Representative.				
2. A Family Advocacy Committee is established.				
3. The FAC consists of the following members: Chairman,Lawyer, Pediatrician, Gynecologist, Psychiatrist or Psychologist, Chaplain, Dental Officer, Social Worker, Pediatric Nurse, Health Care Administrator, Alcohol Rehabilitation Service Representative.				
4. The FAC submits recommendations on program management, expansion, and actions to the Commanding Officer.				
5. The FAP convenes at least once a quarter.				
6. There are three working committees of the FAC: Child Abuse/Neglect; Spouse Abuse/Neglect; Sexual Assault/Rape.				
7. Each working committee is required to meet monthly.				

STRUCTURAL ITEM TOOL--FAMILY ADVOCACY PROGRAM

ITEM DESCRIPTION	PRES.	ABS.	DOCUMENT WHERE ITEM FOUND	COMMENTS
8. Recommendations concerning disposition of cases must be submitted to the Commanding Officer.				
9. There is an established education program for staff to acquaint them with FAP.				
10. A Duty FAR is provided to handle incidents occurring after normal working hours.				
11. The DFAR is designated by name in the Plan of the Day.				
12. The DFAR roster represents a cross-section of local Command personel.				
13. A documented training program is provided for the DFAR's to provide familiarization with instructions, local directives, and local reporting and intervention procedures.				
14. There is a list of resources to be used for tertiary treatment and support.				

STRUCTURAL ITEM TOOL--FAMILY ADVOCACY PROGRAM

ITEM DESCRIPTION	PRES.	ABS.	DOCUMENT WHERE ITEM FOUND	COMMENTS
15. There is a secondary intervention program developed to identify "high risk" individuals and families.				
16. There is a system established for reporting cases diagnosed by working committees as "suspected" or "established" to Chief, BUMED.				
17. There is a command-wide education program to inform staff on how to identify and refer "high risk" families and individuals to the FAP.				
18. There are primary intervention programs developed in conjunction with the FAP.				
19. There are established policies for emergency response to abused/neglected family members in imminent danger which include: Removal from the dangerous situation; emergency medical care; hospitalization; protective custody.				
20. There are standard procedures developed for medical examination of abuse and neglect victims.				

STRUCTURAL ITEM TOOL--FAMILY ADVOCACY PROGRAM

ITEM DESCRIPTION	PRES.	ABS.	DOCUMENT WHERE ITEM FOUND	COMMENTS
21. There are specific policies for the care, evaluation, and full medico-legal documentation of cases of alleged or suspected sexual assault and rape which are consistent with BUMED guidelines.				
22. There is local policy for reporting all incidents of possible abuse, neglect, sexual assault or rape to the FAR or DFAR.				
23. There is established liaison with local military agencies and units to provide for reporting possible incidents.				
24. There is established liaison with civilian agencies to encourage reporting of incidents.				
25. There is a local policy to provide for medical care to abuse victims when parental/sponsor authorization is withheld or unavailable.				
26. There is a specific local policy established for photography of victims which is consistent with BUMED guidelines.				

STRUCTURAL ITEM TOOL--FAMILY ADVOCACY PROGRAM

ITEM DESCRIPTION	PRES.	ABS.	DOCUMENT WHERE ITEM FOUND	COMMENTS
27. There are established local policies which identify legal jurisdiction for military personnel and their families on and off federal reservations and which define geographic areas of exclusive and concurrent jurisdiction in cases of abuse, neglect, sexual assault and rape.				
28. There are procedures established for interagency support and assistance, both military and civilian.				
29. Clearly defined roles for each military and civilian agency are established, including both non-punitive and punitive intervention.				
30. There are specific procedures established in the FAP on how and when to initiate involvement of the various civilian and military agencies.				
31. Guidelines are established for the FAR or DFAR in obtaining the initial clinical interview with the victim.				

STRUCTURAL ITEM TOOL--FAMILY ADVOCACY PROGRAM

ITEM DESCRIPTION	PRES.	ABS.	DOCUMENT WHERE ITEM FOUND	COMMENTS
32. Policies are established which define the legal restrictions on FAR or DFAR interviews with suspected abusers.				
33. Privacy Act restrictions are established for all interviews.				
34. Policies are established which require the FAR to coordinate subsequent interviews with a suspected perpetrator of abuse or neglect with the appropriate military and civilian legal authorities.				
35. There is a public awareness campaign established to inform the local military community about the Family Advocacy Program.				
36. There is an established procedure for the FAR to use in obtaining the social history from victims and families.				
37. There are established policies for obtaining information from collateral resources to utilize in the evaluation, diagnosis, and treatment of abuse/ neglect victims and their families.				

STRUCTURAL ITEM TOOL--FAMILY ADVOCACY PROGRAM

ITEM DESCRIPTION	PRES.	ABS.	DOCUMENT WHERE ITEM FOUND	COMMENTS
38. There is a procedure which requires consensus decision of working FAC committees in their diagnosis and treatment recommendations.				
39. A Family Advocacy Incident Log is established and maintained for all reported incidents of abuse or neglect.				
40. There are specific policies governing the content of FAP files.				
41. There are specific policies governing the release of information in FAP files.				
42. There are specific policies governing the review of FAP files consistent with BUMED guidelines.				
43. There are specific policies governing destruction of FAP closed files after the required holding period of four years.				
44. Specific policies are established for transfer of FAP files when the sponsor is transferred or separated.				

STRUCTURAL ITEM TOOL--FAMILY ADVOCACY PROGRAM

ITEM DESCRIPTION	PRES.	ABS.	DOCUMENT WHERE ITEM FOUND	COMMENTS
45. Specific procedures are established for the identification, maintenance, and review of outpatient medical records of famlies and individuals considered "high risk" by FAP working committees.				
46. There is an established policy for the destruction of FAP files of cases diagnosed as unfounded.				

APPENDIX D

OUTCOME MEASURES DATA COLLECTION TOOL

OUTCOME MEASURES DATA COLLECTION TOOL

Date Record Opened_____

1. FILE CATEGORY (check one):

    Working (no diagnosis established) _____

    Active _____

    Inactive _____

    Closed _____

2. DIAGNOSIS (check as many as apply):

    Physical abuse _____

    Sexual assault, abuse, rape _____

    Physical neglect _____

    Psychological abuse _____

    Unfounded _____

    Suspected _____

    Established _____

    Intentional _____

    Unintentional _____

3. AGE OF VICTIM _____

4. SEX OF VICTIM _____

5. STATUS OF VICTIM (check one)

    Spouse _____

    Child _____

    Active duty _____

6. IDENTITY OF PERPETRATOR _____

7. REFERRAL SOURCE _____

8. HOSPITALIZATION OF VICTIM Yes_____ No_____

9. SPONSOR'S SERVICE AND RANK _____

10. TIME DELAY IN DAYS FROM INITIAL REPORT AND INTERVIEW TO NEXT INTERVIEW WITH FAR. _____

11. TIME DELAY IN DAYS FROM INITIAL REORT TO DIAGNOSIS BY FAC WORKING COMMITTEE. _____

12. SOURCE OF TREATMENT (check one):

    Military _____

    Civilian _____

    Combination _____

    Not applicable _____

13. DRUGS AND/OR ALCOHOL USE INVOLVED IN INCIDENTS? Yes_____ No_____

14. TREATMENT PROGRAM RECOMMENDED? Yes_____ No_____

15. VICTIM ENTERS TREATMENT PROGRAM (check one):

    Yes_____ No_____ Not applicable_____

16. FAMILY ENTERS TREATMENT PROGRAM (check one):

    Yes_____ No_____ Not applicable_____

17. ABUSER/PERPETRATOR ENTERS TREATMENT PROGRAM (check one):

    Yes_____ No_____ Not applicable_____

APPENDIX E

PROCESS REVIEW AUDIT SCORE SHEET

AUDIT SCORE SHEET--PROCESS REVIEW

Date File Opened_____

1. Diagnosis established by FAP working committee. At least one from each of the following three lists must be present.

Established	Physical abuse	Intentional
Suspected	Sexual assault/rape	Unintentional
	Physical neglect	
	Psychological abuse	
	Psychological neglect	

Yes_____No_____

2. Treatment plan established by committee and documented in file.

Yes_____No_____

3. Record review of files by FAR at designated intervals:

Active files--monthly
Inactive files--quarterly
Closed files--yearly

Yes_____No_____

4. Adequate identifying information present, defined as:

Name of victim

Status of victim--e.g. Child, Spouse, Active duty

Name of sponsor

Status of sponsor

Social Security Number of Sponsor

Yes_____No_____

5. Treatment recommendations made available to sponsor's command. Documentation must show contact with sponsor's command.

Yes_____No_____

SCORE_____

APPENDIX F

PROFESSIONAL AWARENESS SURVEY:

COVER LETTER AND QUESTIONNAIRE

02:AJR:acs
16 Feb 1982

MEMORANDUM

From: Commanding Officer
To:

Subj: Family Advocacy Program Research Project

Ref: (a) BUMEDINST 6320.57

Encl: (1) Research Questionnaire

1. Earlier this year,, the Naval Regional Medical Center, Camp Pendleton was designated as a residency site for the U.S. Army-Baylor University Graduate Program in Health Care Administration. The first two residents are on board and have begun their major Graduate Research Projects.

2. One project will involve an in-depth study of the Family Advocacy Program at this hospital. One component of this project is a survey of hospital staff.

3. To assist in this project, it is requested that enclosure (1) be completed and returned by 1 March 82 to CDR A. Rawley, NC USN, Administrative Resident. Your cooperation is greatly appreciated.

L. U. PULICICCHIO

Instructions: Please circle your answer to each question. It is not necessary to sign the questionnaire. Return the completed questionnaire, marked for CDR A.J. Rawley, Administrative Resident, to Central Files.

1. Sex

a. Male b. Female

2. Professional or Occupational classification

a. Physician

b. Physician's Assistant

c. Registered Nurse

d. Hospital Administration

e. Allied Health Professional

f. Hospital Corps

3. Do you know how to recognize possible incidents of child abuse/neglect; spouse abuse/neglect; sexual assault; and rape?

a. Yes b. No

4. Do you know where and how to report such incidents if they come to your attention?

a. Yes b. No

5. Given the limited nature of resources, what do you think should be the role of the military medical center in family advocacy? (Circle as many answers as you choose.)

a. Reporting

b. Intervention

c. Treatment

d. Prevention

e. None of the above

6. Have you received information, such as printed material or inservice education, on the NRMC Family Advocacy Program?

a. Yes b. No

APPENDIX G

PUBLIC AWARENESS QUESTIONAIRE

Dear Patient:

As part of a hospital sponsored research effort, you are asked to complete this questionnaire. Your participation is strictly voluntary and your assistance in this research is greatly appreciated.

Commanding Officer
Naval Regional Medical Center
Camp Pendleton, California

Instructions: Circle your answer to each question and return the form to the desk where you received it. Do not sign the form. Thank you.

1. Status

a. Active duty, Officer
b. Active duty, Enlisted
c. Retired, Officer
d. Retired, Enlisted
e. Dependent spouse, active duty
f. Dependent spouse, retired
g. Other

2. Branch of service, member or sponsor

a. Navy
b. Marine Corps
c. Army
d. Air Force
e. Coast Guard
f. Other

3. Marital Status

a. Married b. Single c. Widow or widower

4. Sex

a. Male b. Female

5. Have you received information regarding the Family Advocacy Program?

a. Yes b. No

6. Were you aware that this hospital has services to help with problems such as child abuse/neglect and spouse abuse/ neglect?

a. Yes b. Nc

7. If you or your family were having problems with child abuse or spouse abuse, would you seek help at this hospital?

a. Yes b. No

APPENDIX H

INTERVIEW GUIDE FOR MEMBERS OF THE FAMILY ADVOCACY COMMITTEE AND SUB-COMMITTEE

INTERVIEW GUIDE FOR MEMBERS OF THE FAC AND SUB-COMMITTEES

1. Occupational/Professional Status

2. What do you think the objectives of the hospital's FAP should be?

   a. Identification of cases

   b. Diagnosis of cases

   c. Treatment of cases

   d. Prevention

   e. Other_____

_____

3. In what areas is the current NRMC FAP effective?

   a. Identification of cases

   b. Diagnosis of cases

   c. Treatment of cases

   d. Prevention

   e. Other_____

_____

4. What is your opinion of the BUMED Instruction 6320.57 on the FAP?

   a. Not familiar with it

   b. Provides adequate guidelines

   c. Inadequate because_____

_____

5. Comments/Suggestions about the FAP:

APPENDIX I

HYPOTHESIS TESTING VALUES USED IN THE RESEARCH

HYPOTHESIS TESTING VALUES*

Structure Review

1. Proportion of items missing: 0.74.

2. Null hypothesis: Proportion of items missing is less than or equal to fifty percent of total sample.

3. Alternative hypothesis: Proportion missing is greater than fifty percent.

4. Critical value of the test statistic: 1.645 for the 0.05 level of significance.

5. Computed value of the test statistic: 3.256.

6. Decision: Reject null hypothesis (p-value is less than 0.001).

Outcome Measures--Child Abuse Incidence Rate

1. Proportion in local population: 0.005.
   Proportion in general population: 0.0088.

2. Null hypothesis: Difference of the general population proportion minus the local population proportion is less than or equal to zero.

3. Alternative hypothesis: Difference of the general population proportion minus the local population proportion is greater than zero.

4. Critical value of the test statistic: 1.645 for the 0.05 level of significance.

5. Computed value of the test statistic: 0.3247.

6. Decision: Cannot reject null hypothesis (p-value equals 0.3745).

*Tests taken from Wayne W. Daniel, Biostatistics: A Foundation for Analysis in the Health Sciences, Second edition (New York: John Wiley & Sons, 1978), p. 1959-91.

Outcome Measures--Spouse Abuse Incidence Rates

1. Proportion in local population: 0.005.
Proportion in general population: 0.042.

2. Null hypothesis: Difference of the general population proportion minus the local population proportion is less than or equal to zero.

3. Alternative hypothesis: Difference of the general population proportion minus the local population proportion is greater than zero.

4. Critical value of the test statistic: 1.645 for the 0.05 level of signigicance.

5. Computed value of the test statistic: 1.727.

6. Decision: Reject the null hypothesis (p-value equals 0.0427).

Outcome Measures--Sexual Assault Incidence Rates

1. Proportion in local population: 0.00052.
Proportion in general population: 0.0004.

2. Null hypothesis: Difference of the general population proportion minus the local population proportion is less than or equal to zero.

3. Alternative hypothesis: Difference of the general population proportion minus the local population proportion is greater than zero.

4. Critical value of the test statistic: 1.645 for the 0.05 level of significance.

5. Computed value of the test statistic: 0.04.

6. Decision: Cannot reject the null hypothesis (p-value equals 0.484).

Outcome Measure--Compliance with Treatment Program

1. Proportion of cases showing compliance: 0.42

2. Null hypothesis: Proportion of cases showing compliance is less than or equal to fifty percent of total sample.

3. Alternative hypothesis: Proportion of cases showing compliance is greater than fifty percent of the total sample.

4. Critical value of the test statistic: 1.645 for the 0.05 level of significance.

5. Computed value of the test statistic: -2.59.

6. Decision: Cannot reject null hypothesis (p-value is 0.0048).

Process Review

1. Proportion of files scoring three or greater: 0.11.

2. Null hypothesis: Proportion of files scoring three or greater is less than or equal to fifty percent of total sample.

3. Alternative hypothesis: Proportion of files scoring three or greater is more than fifty percent of the total sample.

4. Critical value of the test statistic: 1.645 for the 0.05 level of significance.

5. Computed value of the test statistic: -17.125.

6. Decision: Cannot reject the null hypothesis (p-value is less than 0.001).

Professional Awareness Survey

1. Proportion of respondents answering yes to two or more of the three questions: 0.61.

2. Null hypothesis: Proportion of respondents answering yes to two or more questions is less than or equal to fifty percent of total sample.

3. Alternative hypothesis: Proportion of respondents answering yes to two or more questions is greater than fifty percent of the total sample.

4. Critical value of the test statistic: 1.645 for the 0.05 level of significance.

5. Computed value of the test statistic: 3.35.

6. Decision: Reject the null hypothesis (p-value is less than 0.001).

Public Awareness Survey

1. Proportion of respondents answering yes to one or more of the two questions: 0.46.

2. Null hypothesis: Proportion of respondents answering yes to one or more questions is less than or equal to fifty percent of total sample.

3. Alternative hypothesis: Proportion of respondents answering yes to one or more questions is greater than fifty percent of the total sample.

4. Critical value of the test statistic: 1.645 for the 0.05 level of significance.

5. Computed value of the test statistic: -1.59.

6. Decision: Cannot reject the null hypothesis (p-value equals 0.056).

APPENDIX J

ESTIMATES OF POPULATION FOR NRMC CAMP PENDLETON CATCHMENT AREA USED IN DETERMINING INCIDENCE RATES

POPULATION ESTIMATES*

Children (below 18 years of age, military beneficiaries only):	17,383
Married couples (active duty and retired):	28,209
Adult females (over 18 years of age, milirary beneficiaries):	24,927

*Based upon figures provided by NRMC Public Affairs Officer and Joint Public Affairs Office, Camp Pendleton.

APPENDIX K

CALUCULATION OF COSTS FOR FAMILY ADVOCACY PROGRAM

1. Direct Service Time Units Available in Social Work Service.

2,080	Average number of hours per year per social worker.
X	
3	Number of social workers providing direct service.
=	
6,240	Work hours available per year.
-	
672	Hours of annual leave per year for three workers.
=	
5,568	Numer of hours available for 3 workers per year.
X	
0.7	Estimated percent of time available for direct patient service.
=	
3,897	Total direct service hours per year.
X	
4	Number of 15-minute time units per hour.
=	
15,588	Total estimated direct service time units per hour.

2. Annual Cost per direct service time unit (15-minute).

$78,105.80	Total annual Social Work Service Budget for fiscal year 1981.
÷	
15,588	Total estimated direct service time units available annually.
=	
5.01	Average cost per 15-minute time unit.

3. Time and Cost per Social Work Service Visit.

15,588	15-minute time units available annually.
÷	
3,465	Total number of visits in fiscal year 1981.
4.5	15-minute time units used per visit.
X	
15	Number of minutes per time unit.
=	
68	Average number minutes per visit.

4. Cost for Family Adovcacy Cases.

277	Number of Family Advocacy cases in 1981.
÷	
392	Total Social Work Service Cases in 1981.
=	
71%	Proportion of cases attributed to Family Advocacy Program.
X	
$78,105.80	Total annual budget for Social Work Service.
=	
$55,455.12	Total annual cost for Family Advocacy Program.

5. Time Direct Service Providers Spend in Famly Advocacy Program Meetings.

Family Advocacy Committee	
11 providers x 4 hours per year =	44
Spouse Abuse and Child Abuse Subcommittees	
14 providers x 24 hours per year =	360
High Risk, Sexual Assault/Rape, and Education Subcommittees	
19 providers x 12 hours per year =	228
hours annually	632

BIBLIOGRAPHY

Books

American Hospital Association. Cost Accountability for Hospital Social Work. Chicago: American Hospital Association, 1980.

_____. Professional Standards Review for Hospital Social Work. Chicago: American Hospital Association, 1977.

Austin, Donald F., and Werner, S. Benson. Epidemiology for the Health Sciences. Springfield, Ill.: Charles C. Thomas Publishers, 1974.

Daniel, Wayne W. Biostatistics: A Foundation for Analysis in the Health Sciences. 2nd ed. New York: John Wiley & Sons, 1978.

Hunter, Edna J., and Nice, D. Stephen, ed. Children of Military Families--A Part and Yet Apart. Washington, D.C.: U.S. Government Printing Office, 1978.

Isaac, Stephen. Handbook in Research and Evaluation. San Diego: EdITS publishers, 1980.

Joint Commission on Accreditation of Hospitals. Accreditation Manual for Hospitals, 1982 Edition. Chicago: Joint Commission on Accreditation of Hospitals, 1981.

Schmitt, Barton D., ed. The Child Protection Team Handbook. New York: Garland STPM Press, 1978.

Articles and Periodicals

Accord, L.D. "Child Abuse and Neglect in the Navy". Military Medicine 142 (November 1977):862-4.

Ayoub, Catherine, and Pfiefer, Donald R. "An Approach to Primary Prevention: The At Risk Program". Child Today 6 (May-June 1977):14-7.

Burt, Marvin R. "Final Results of the Nashville Comprehensive Emergency Services Project". Child Welfare 55 (November 1976):661-4.

Cohn, Anne Harris; Ridge, Susan Shea; and Collignon, Frederick C. "Evaluating Innovative Treatment Programs in Child Abuse and Neglect". Child Today 4 (May-June 1975):10-2.

Cunningham, Louise. "Child Abuse Policies and Procedures: The Experience at St. Mary Medical Center". Quality Review Bulletin 6 (September 1980):27-31.

Deller, C.R.; Fatin, N.A.; and Stewart, L.A. "Sexual Assault Referral Centre, Perth: The First Thirty Months". Australian Family Physician 8 (July 1979):77-5.

Evans, Hannah I., and Sperekas, Nicole B. "Community Assistance for Rape Victims". Journal of Community Psychology 4 (October 1979):1448.

Evrard, John R., and Gold, Edwin M. "Epidemiology and Management of Sexual Assault Victims". Obstetric and Gynecology 53 (March 1979):378-81.

Finley, Britt. "Nursing Process with the Battered Woman". Nurse Practitioner 6 (July-August 1981):11-3.

Fitzpatrick, Lynda. "A Team Approach to Child Abuse". Canadian Nurse 75 (January 1979):36-9.

Flanzer, Jerry. "The Vicious Circle of Alchoholism and Family Violence". Military Family 1 (Fall 1981): 3-4.

Friedrich, William N., and Bariskin, Jerry A. "Primary Prevention of Child Abuse: Focus on the Special Child". Hospital Community Psychiatry 29 (April 1978):248-51.

Gottesman, Sharon Tennstedt. "Police Attitudes Toward Rape Before and After a Training Program". Journal of Psychiatric Nursing 15 (December 1977):14-8.

Grazia, Thomas F. "New Perspectives on Child Abuse/Neglect Community Education". Child Welfare 60 (May 1981): 343-53.

Hicks, Dorothy J. "Rape: Sexual Assault". American Journal of Obstetrics and Gynecology 137 (August 15, 1980): 932-5.

Hilberman, Elaine. "Overview: The 'Wife-Beater's Wife' Reconsidered". American Journal of Psychiatry 137 (November 1980):1336-47.

Kaufman, Arthur; DiVasto, Peter; Jackson, Rebecca; Voorhees, Dayton; and Christy, Joan. "Male Rape Victims: Noninstitutionalized Assault". American Journal of Psychiatry 137 (February 1980):221-3.

Kerns, David L.; Cavanaugh, Jane; and Berliner, Benjamin C. "Child Abuse and Neglect: The Hospital's Expanding Role in Prevention, Identification, and Management". Connecticut Medicine 43 (May 1979):293-300.

McCombie, Sharon L.; Bassuk, Ellen; Savitz, Roberta; and Pell, Susan. "Development of a Medical Center Rape Crisis Intervention Program". American Journal of Psychiatry 133 (April 1976):418-21.

Nagi, Saad Z. "Child Abuse and Neglect Programs: A National Overview". Child Today 4 (May-June 1975):13-7.

Price, Jessica M., and Valdeserri, Edwin B. "Childhood Sexual Abuse: A Recent Review of the Literature". Journal of the American Medical Women's Association 36 (July 1981):232-4.

Rosik, Don C. "A Model for Systematic Child Protective Service Training". Child Welfare 58 (July-August 1979):429-33.

Schmitt, Barton D. "Current Pediatric Roles in Child Abuse and Neglect". American Journal of Diseases in Children 133 (July 1979):691-6.

Schneider, D. Jean; Blydenburgh, Donald; and Craft, Gail. "Some Factors for Analysis in Sexual Assault". Social Science Medicine 15A (January 1981):55-61.

Sefcik, Thomas R., and Ormsby, Nancy J. "Establishing a Rural Child Abuse/Neglect Tretment Program". Child Welfare 57 (March 1978):187-95.

Solomons, Gerald. "Trauma and Child Abuse. The Importance of the Medical Record". American Journal of Diseases in Children 5 (May 1980):503-5.

Stark, Evan; Flitcraft, Anne; and Frazier, William. "Medicine and Patriarchal Violence: The Social Construction of a 'Private' Event". International Journal of Health Services 9 (March 1979):461-93.

Sundel, Martin, and Homan, Carolyn Clark. "Prevention in Child Welfare: A Framework for Management and Practice". Child Welfare 58 (July-August 1979): 510-21.

Tilelli, John A.; Turek, Dianne; and Jaffe, Arthur C. "Sexual Abuse of Children: Clinical Findings and Implications for Management". New England Journal of Medicine 302 (February 7, 1980):319-23.

Wardinsky, Terrance, and Kirby, William. "A Review of Child Maltreatment at a USAF Medical Center". Military Medicine 146 (May 1981):328-31.

Whitworth, Jay M.; Lanier, Michael W.; Skinner, Richard G.; and Lund, Nick L. "A Multidisciplinary Hospital-Based Team for Child Abuse Cases: A 'Hands-on' Approach". Child Welfare 60 (April 1981): 233-43.

Reports

Hunter, Edna J., and Shaylor, Thomas C., ed. The Military Family and the Military Organization. San Diego: United States International University, [1978].

Lerman, Lisa G. Legal Help for Battered Women. Washington, D.C.: Center for Women Policy Studies, [1980].

Government Publications

U.S. Congress. House. Report by the Comptroller General on Military Child Advocacy Programs. HRD 79-75, May 23, 1979.

U.S. Department of Defense. Family Advocacy Program. Directive No. 6400.1, May 19, 1981.

U.S. Department of Health and Human Services. National Center on Child Abuse and Neglect. Child Abuse and Neglect Among the Military. DHHS Publication No. (OHDS) 80-30275. Washington, D.C.: Herner and Company, 1980.

_____. Child Protection in Military Communities, by Diane D. Broadhurst, Russell S. Estey, William Hughes, James L. Jenkins, and James A. Martin. DHHS Publication No. (OHDS) 80-30260. Washington, D.C.: Kirschner Associates, Inc. 1980.

_____. Interdisciplinary Glossary on Child Abuse and Neglect: Legal, Medical, Social Work Terms. DHHS Publication No. (OHDS) 80-30137. Washington, D.C.: U.S. Government Printing Office, 1980.

U.S Department of the Navy. Bureau of Medicine and Surgery. Family Advocacy Program. Instruction 6320.57, July 11, 1979.

_____. Health Care Quality Assurance/Risk Management Program; establiment of. Instruction 6320.62, May 29, 1981.

END

DATE

FILMED

8-88

DTIC